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BIRTH CONTROL ON TRIAL

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By

LELLA SECOR FLORENCE

With a Foreword by

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LELLA SECOR FLORENCE

(*Formerly Honorary Secretary of the Cambridge Women's Welfare Association*)

FOREWORD

BIRTH control is a difficult subject and arouses rather vigorous expressions of condemnation from those whose convictions must be respected as evidence of sincere anxiety as to its effect on public morals. From the not unnatural disinclination to discuss an unpleasant subject there has been at any rate in the past a reticence entirely out of proportion to the prevalence of the practice. As a result there is a want of accurate information about many aspects of a subject which, whatever the views publicly expressed, is of great importance from wide national as well as individual points of view.

Unbiassed investigations into various problems connected with birth control are now being undertaken, and of these Mrs. L. S. Florence's report, entitled *Birth Control on Trial*, is a model example of how the data should be obtained and marshalled. It gives the experience gained from the history of the first three hundred applicants at the Cambridge Birth Control Clinic from August 5, 1925, to May 24, 1927. The amount of persevering labour undertaken by the author is shown by the fact that information as to the success or failure attending the advice given was obtained from all but twenty-five of the two hundred and seventy-two to whom such advice was actually given. The result is a frank admission of the difficulties and limitations of the technique of birth control, or the various forms of contraceptive methods. The patient investigation of the after-history of the applicants shows that it is fallacious to assume that those who do not return to the clinic have been successful in

their application of the instruction received. In fact the data accumulated by the conscientious following-up of the applicants are disappointing, in that they prove contraceptive methods to be neither so simple or certain as has been stated by some enthusiastic writers on the subject. In addition to the experience gained at the Cambridge Clinic the results and opinions of others are given, making this report extremely valuable, especially because of its transparent honesty in recording what must surely have been an unwelcome result. The accounts of illustrative cases are very human documents and throw convincing light on the pitiful plight of the multiparous mothers of the poor and of their unwanted children.

HUMPHRY ROLLESTON

INTRODUCTORY NOTE

IT is not out of place to record here, in a few introductory words, the manner of origin and early history of the Cambridge Women's Welfare Association. The main incentive which brought this institution into existence was undoubtedly philanthropical. It was not from a desire for scientific inquiry, though this motive may have influenced some of the subsequent supporters of the movement, neither was it from any sort of political motive, that the Association came into being, but rather as a result of the realization borne in upon the social workers of Cambridge that one of the greatest needs—perhaps the greatest—of the industrial classes in our midst was some certain and simple way of regulating the size of their families and preventing the arrival of unwanted children, for whom there was no accommodation and who only added to the already existing discomfort.

In this movement, Mrs. Florence, the author of this book, took the initiative, but she was not long in receiving support from other social workers who also knew from intimate experience of the conditions among the poorer classes how great was the need that something should be done. A meeting of women was held in March 1925, and a further meeting of men and women in the following May, when the first officers were elected and the Women's Welfare Association formally launched. Among those who gave their active support in those early days of the movement for a birth-control clinic in Cambridge, special mention must be made of the late Mrs. Agnes Ramsey, whose help and guidance were invaluable, and

Mrs. Eva Hartree, at that time Mayor of Cambridge. The Association has received support both from the town and the University, many of the younger members of which have shown an active interest. It is to be noted also that among the supporters of the Association are members of all political parties and a number of different religious denominations.

That the Association has been a success is abundantly shown by the record contained in this book by Mrs. Florence, to whom so much of the credit is due; but its progress has also been attended by many difficulties, some of which have not yet been dissipated. The need for investigation into birth-control methods is sufficiently emphasized in these pages; but while agreeing with the author in her main contentions in regard to this matter, I wish to urge that a method must not be written down as a failure because it is sometimes unsuccessful, and that success must be judged on the average results obtained. What is true of medicines and drugs applies also to contraceptive methods. It is only in advertisements that a particular remedy or preventative is *always* successful, and although our ideal is to obtain a method of control which is "fool proof", so that even the most unintelligent can adopt it successfully, this is a counsel of perfection which may be hard or even impossible to attain. An appreciation of this point should not dishearten those of us who believe in birth control, but should rather encourage us in persisting in a movement, the results of which are already amply justified by what has undeniably been accomplished in the alleviation of hardship.

The population question is ever with us, and as time

proceeds is likely to grow increasingly acute. Eugenic considerations are being more and more brought under the public notice, and the community as a whole is becoming aroused to their importance. The subject is still one of contention, and much feeling is being brought to bear upon it, but to those who realize the true nature of our social and economic conditions it is evident that birth control must play a leading part in raising our standards of ethical practice and in promoting the development of our civilization.

F. H. A. MARSHALL

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CHAPTER I

A PROSPECTUS

THIS book is undertaken as a dispassionate and honest inquiry into the methods of contraception advised at the Cambridge Birth Control Clinic. It is based on the first three hundred cases. All of these patients who could be traced, or who lived within a radius of twenty-five miles from Cambridge, were called upon by the author at least once after they visited the Clinic, and in some cases two or three times. Three hundred and thirty-one calls were made in all.

The investigation was undertaken because of a growing conviction that the existing methods of birth control were not proving as successful in practice as we ourselves had expected, or as birth-control enthusiasts in general seemed to believe. If the results of the investigation had proved these fears to have been groundless, this report would never have been written; for it is obvious that three hundred *successful* cases would be too small a number on which to base any conclusions if all the other possible factors contributing to infertility were to be duly considered. But the results which have in fact been obtained seem worth while setting down as throwing considerable light on the difficulties and failures which the women have experienced in attempting to apply those contraceptive measures which are to-day available.

We do not offer this report as a conclusive statistical study of the relative merits of contraceptive methods. But we do offer it as a precise and scrupulous examination, case by case, of the experience of women who have attempted deliberately to limit their families. We believe that it is more enlightening to *know* what has happened in three hundred cases than to *surmise* what has happened in five thousand. We have proceeded with the resolute determination not to allow our avowed bias in favour of birth control to hinder us from seeing and recording honestly the facts as we found them. Sentimentality and romantic fancies about birth control have no place in this account.

The investigation has strengthened our conviction that adequate family limitation is beyond all doubt absolutely essential to the health, happiness, and economic stability of married couples. We are convinced that the only procedure by which accurate information can be gathered concerning the success of any method of contraception is to seek it at the source, i.e. by personal interview of the woman who is using the contraceptive, a procedure which we confidently hope will be developed on a much larger scale.

We feel that the present investigation offers fairly convincing evidence that such contraceptives as can now be recommended are neither simple nor certain enough to meet the needs of a very large body of women whom it is most desirable to restrain from propagating; and that even when they are being successfully employed by intelligent men and women they present so many disadvantages and drawbacks as to act as an impediment to

the full realization of the pleasures and benefits inherent in the sexual act.

In view of this evidence we feel we are justified in urging the medical profession to turn its earnest attention forthwith to scientific research in this important and too long neglected field. There can be no doubt that birth-control knowledge, which has spread with such amazing rapidity in the past few years, will be more and more widely disseminated; and the general public, and women in particular, have a right to demand that birth control shall be extricated from the confusion and uncertainty, the doubt and dissatisfaction, which now envelops it, and placed on a sound scientific basis. This is the concern of the medical profession. And until the medical profession takes a serious view of its responsibilities in this matter,[1] the misery, the suffering, the bitterness of unwilling women coerced into producing unwanted children, must stand as an indictment of the indifference of science to a matter of such far-reaching importance both to the individual and to the race.

[1] As some medical men are doing individually. Special mention should be made of Dr. C. P. Blacker, who organized the International Medical Group for the Investigation of Birth Control, and who edits and publishes from time to time reports submitted by medical representatives in different countries.

CHAPTER II

HISTORICAL SPECULATIONS

WHEN the Cambridge Clinic was opened in August 1925 we undertook the work of giving birth-control information with the greatest optimism. We thought that birth control was easy and simple, and that we had only to make appliances accessible to women to solve the difficulties of unwanted pregnancies—a view which seems still to be shared by that part of the general public which is consciously aware of the subject at all. The belief that prevention of conception is simplicity itself is of no recent origin, and the fact that up to this time there has been no systematic collection of data to shatter the illusion may account for its persistence.

In the handbills distributed by Francis Place in 1823 —copies of which are preserved in the Place collection at the British Museum—he talks of "an easy, simple, cleanly, and not indelicate method" when he advises the use of a medicated sponge, and naïvely informs his readers that "the use of the sponge will render all other precautions unnecessary". In 1898, when the fourth edition of the *Malthusian Handbook* was printed, we find this assurance:

> Medical science has shown that the size of families is absolutely under the control of parents if they will but exercise a reasonable degree of care and forethought. A young couple may now enter the marriage state without misgiving, for the number of their offspring can be regulated in proportion to their means as surely as they can determine the amount of their expenditure upon clothing or luxuries.

And in the vast volume of literature which has poured from the Press on the subject of birth control in the past few years, one is confronted by an easy assurance that this or that method can be, and has continually been, applied with the greatest success.

It is perhaps not surprising that we have so little tabulated experience by which to measure the validity of these claims. For though it is certain that family limitation has been attempted on a large scale in one form or another for many generations—for many centuries, in fact—it is only in very recent years that the subject has come into the open. It is, perhaps, too much to expect that any statistics should have emerged from an age when everything pertaining to sex was hidden under a dark cloud of taboo. Not in the Victorian era did engaged couples calmly deliberate on the number of children they proposed to produce! If contraceptive measures were discussed amongst the harassed parents of too quickly sprouting families, it was done with the utmost discretion. Even the Bradlaugh–Besant trial, heralded as it was by publicity, scarcely penetrated the drawing-rooms of the "best families", whose sheltered young ladies remained in ignorance of the vast changes which were beginning to affect public opinion.

For knowledge of birth control was spreading even though the age of clinics and open discussion in drawing-rooms and public meetings had not yet arrived. Methods were advocated with zeal and assurance, even though assumptions as to their effectiveness were based on the scantiest and most hearsay information. And intelligent women were beginning seriously to question the advis-

ability or the necessity of producing the enormous families of their grandmothers. Even Queen Victoria, in a letter she wrote to the King of the Belgians on January 15, 1841, was taking a serious view of her responsibilities in this respect:

I think, dearest Uncle, you cannot *really* wish me to be the "Mamma d'une nombreuse famille", for I think you will see with me the great inconvenience a *large* family would be to us all, and particularly to the country, independent of the hardship and inconvenience to myself; men never think, at least seldom think, what a hard task it is for us women to go through this *very often*.[1]

At this time practically all contraceptive information was disseminated in printed form—practically all—for very few doctors indeed were informed on the subject of birth control, and the numerous "rubber stores" had not achieved that easy accessibility which they now enjoy. Naturally there was no means of keeping a record of the efficiency or failure of the contraceptives employed under these circumstances.

This dissemination of birth-control information—that is, definite instruction in the use of such means as were known—followed hard upon the heels of Malthus's population theories in the early part of the nineteenth century. In the summer of 1823 Place drew up four handbills addressed "To The Married of Both Sexes—the "diabolical handbills"—which he undertook to distribute among the populace by secret and ingenious means. He advocated *coitus interruptus*, or the use of a medicated sponge, and seemed convinced that either was easy and effective. Richard Carlile's *Every Woman's Book*, published in 1826, appears to have been the first birth-

[1] *Letters of Queen Victoria*, 1837–1861, vol. i. p. 255.

control book printed in the English language, but it is difficult to guess how wide its circulation was. Knowlton's pamphlet, *The Fruits of Philosophy*, which followed in 1832, seems not to have excited any great stir—the author was, in fact, allowed to serve a three months' sentence with hard labour in America where the work originated, without more than a passing comment from a few liberal thinkers. Knowlton mentions the sponge, but is doubtful whether it can be relied upon, and for his part places reliance on "syringing the vagina immediately after connection with a solution sulphate of zinc, of alum, pearl ash, or any salt that acts chemically on the semen and at the same time produces no unfavourable effect in the female".[1] At the same time Robert Dale Owen's *Brief and Plain Treatise on Moral Philosophy*, issued in 1830, in which he advocated chiefly *coitus interruptus*, ran into five editions within seven months.

But when the Knowlton pamphlet precipitated the Bradlaugh–Besant trial in 1877–79 its circulation went rocketing up to unprecedented figures. There followed numerous other leaflets and pamphlets all bent upon helping anxious parents to restrict their families, and all enjoying the searchlight of publicity which played upon the famous trial. Mr. Norman Himes says that he is "certain that no less than a million tracts furnishing elaborate contraceptive information were sold between 1876 and 1891".[2] And he is inclined to think that two million would be the more accurate figure.

[1] *Fruits of Philosophy*, p. 40.
[2] "Charles Knowlton's Revolutionary Influence on the English Birth-Rate", *The New England Journal of Medicine*, vol. 199, No. 10, pp. 461–465, September 8, 1928.

Nor has there been any cessation in this flow of contraceptive advice. Mr. Himes, bringing his reckoning to a more recent date, hopes "to substantiate the estimate that not less than fifteen million books, pamphlets, brochures, leaflets, etc., giving actual contraceptive advice of a medical nature, have been sold or given away in England since the declaration of peace in 1918".[1]

No one will ever know the exact measure of success attained by that vast company who have attempted to follow the instructions set forth in these millions of leaflets. If this information were available, all doubt and controversy as to the comparative value of various methods could certainly be laid at rest; and the debate as to whether the crude birth-rate has in fact been influenced by birth control, or whether natural infertility or other factors can account for the sharp fall in the birth-rate, could be settled for all time. Judging from the difficulties that beset patients even when they have the advantage of personal instruction at a clinic, one is led to surmise that many of the family limitators met with disappointing results. But the enormous scale on which these tracts have been circulated gives unmistakable evidence that prudent folk have been eagerly seeking some relief from the troublesome burden of over-large families throughout the past century.

The fall in the English birth-rate, the commencement of which synchronizes so remarkably closely with that period in English history when birth-control literature began to have a wide circulation, leads to the inference

[1] "British Birth Control Clinics: Some Results and Eugenic Aspects of their Work", *The Eugenics Review*, vol. xx, No. 3, October 1928.

that if the contraceptives advocated have not completely prevented unwanted pregnancies, they have tended to a less frequent occurrence of pregnancy. We have every reason to suppose that if the contraceptives had been completely successful, the fall in the birth-rate would have been very much steeper still.

Considering our known experience in clinics nowadays, we may be sure that a certain number who bought and read the leaflets did so out of curiosity and general interest and probably never tried to apply the advice themselves; a certain number went so far as to purchase a sponge and the necessary medicaments, but never found courage to try them; a certain number employed the methods with complete success; and a certain number tried and failed after varying intervals during which there is every reason to suppose other children would have been born if no contraceptive had been employed. In our own clinic, for instance, we have many cases of parents employing *coitus interruptus* throughout all or part of their married life, despite the fact that it had failed on four or five occasions. The assumption that there might have been ten children instead of five if this effort at limitation had not been made seems perfectly justified.

In the absence of any statistical data as to the effectiveness of any contraceptive—a gap which can never be filled so far as the past is concerned—the question whether conscious attempts at family limitation have been successful enough to affect the birth-rate must be debated on other evidence. Dr. F. A. E. Crew, addressing the British Medical Association, expressed the view that

"it was very doubtful indeed that birth control had affected the population growth-cycle—the crude birth-rate. The fall in the birth-rate had been too gentle. . . . It would seem, therefore, that the fall must be the expression of some biological factors, and not due directly to some local social disturbance which produced repercussions throughout the world."[1]

Mr. Udny Yule offers the evidence of an investigation in which it was found that parents who admitted having attempted limitation had families of about the same size as those who denied any use of contraceptives, and concludes: "Surely it cannot be pretended that a reference to contraceptive measures goes far to explain the fall in fertility or even indicates the chief means by which it has been effected."[2] One wonders whether in the investigation cited by Mr. Yule *coitus interruptus* was definitely included as a contraceptive method when the families denying any attempt at limitation were questioned. Experience at Cambridge shows that when women are asked about the contraceptive measures they have tried they invariably think only of mechanical or chemical appliances, and never include *coitus interruptus*. When *coitus interruptus* had been the only method they had ever employed, we always got a negative answer to our question about previous methods. But when we specifically referred to withdrawal, we almost invariably got the reply, "Oh, yes, he's always been careful." *Coitus interruptus* has without doubt been more widely used than any other method, and despite its acknowledged

[1] Report in *The Times*, July 28, 1928.
[2] *The Fall of the Birth-Rate.*

uncertainty its influence on the birth-rate must have due consideration.

The view that conscious limitation has not affected the birth-rate has been challenged by many writers on the subject. Professor Carr-Saunders says: "We are not able to measure the prevalence of the different forms of conscious limitation and thus definitely to associate them with the declining birth-rate. We do not find, however, any such increase in other factors, such as venereal disease, which diminish fertility, as will account for the facts. We have no reason for supposing that fecundity has diminished, and as we have strong reasons for thinking that conscious limitation has been increasingly practised, we must attribute the change to this cause."[1]

This point of view is also advanced by Mr. Sidney Webb (now Lord Passfield), Sir William Beveridge, Lord Dawson, Professor Sargant Florence, and other writers.[2]

The time seems close at hand when this question, and all the other questions concerning the effect of contraceptives which have been left hitherto in the realm of speculation, may be approached from a more scientific angle. For since 1921, when the first birth-control clinics[3] were opened in England, a dozen new centres have been established. More than twenty thousand women have already registered at these clinics seeking contraceptive

[1] *The Population Problem*, p. 287.

[2] See *The Decline in the Birth-Rate*; *Ethics of Birth Control*, pp. 165–168 and p. 38; *Over-population, Theory and Statistics*, pp. 44–48; *Medical Aspects of Contraception*, p. 4.

[3] The Mothers' Clinic, opened by Dr. Marie Stopes and her husband in April, and the Walworth Clinic, which was launched in the autumn.

instruction, and the work continues to spread and increase. Careful records are kept at these centres, and if cases are conscientiously followed up we shall be able eventually to base our judgment on genuine empirical evidence.

CHAPTER III

CLINICAL EXPERIENCE

OUR avowed object in starting the Cambridge Clinic was to make contraceptive information available to the workers who find it more difficult to get instruction than the well-to-do. We have never had any occasion to fear that our efforts have caused an alarming fall in the birth-rate amongst the workers, and we cannot share the panic of the undergraduate who wrote in an essay on Population: "It is obvious that in the present system the working classes must greatly outnumber the rich in order to keep industry alive. If the birth-rate among the poor fell to such an extent that the upper and lower classes became anything approaching equal in numbers, all foreign trade and industry of every kind would fail." Nor are we moved—except to smile—by the warning of another undergraduate writing on the same subject: "If, however, the birth-rate [amongst the poor] still fell, then very grave results might be expected. First there would be a great shortage of available labour, and the labourer would be up for competition and would take the best price offered him. There would be an increasing demand for a decreasing supply which would place the poorer classes in too certain a position, and in fact there probably would be no poor classes."

The results of our investigation might set the young man's mind at rest, for it seems more than likely that the poor will still be with us until we have found much more effective contraceptives than are known at present.

The Cambridge Clinic was opened by the Women's Welfare Association, organized for that sole purpose. It was affiliated to the Society for the Provision of Birth Control Clinics, which has sponsored most of the clinics existing to-day. This Society operates the Walworth Clinic—one of the two pioneer centres opened in 1921—which has always served as a model and a training-school for doctors and nurses. Our doctors and nurse had advantage of this training, and we proceeded to operate the Centre along the lines laid down by the older Centre, and adopted by all the other affiliated clinics.

From the beginning we tried to create a friendly atmosphere and to dispel the acute nervousness and apprehension of the women. As honorary secretary of the Association I interviewed each woman myself and took particulars for her case-card. This repeated attendance of the same person at each session proved invaluable, for I was able to talk to the women on their subsequent visits, or to visit them later in their homes on the cordial basis of a past acquaintanceship. I think I was able to gather details of a more intimate nature from the women than would have been possible otherwise. It is not always easy to get the truth from a patient on her first visit—she is nervous and ashamed and evasive. We found that, in many cases, the facts originally recorded had to be considerably revised on subsequent interviews—even large sections of family were sometimes omitted in the first confusion, and very often miscarriages and deliberate abortions, which were at first concealed, came to light later. On one occasion a patient told me she had four

children, and I took down all their ages. On the next visit she insisted she had had five.

"But", I said, "I thought you had only four."

"Yes," she replied gaily, "four since I got married. The other one I got by myself."

Her first experience of motherhood, which occurred when she was seventeen (before she had learned to read or write), had been concealed lest it should prejudice her case, for she was desperately determined not to have more children. She is an ardent propagandist, and often brings to the Clinic a total stranger whom she has found on the street with a perambulator full of babies!

The investigation which we undertook was made easier both because it was possible for one person to do all, or nearly all, of the interviewing, and because we normally had sufficiently small attendances so that we never hurried through a case. Every woman was encouraged to talk about herself and her experiences as long as she felt inclined. In these two respects our small Clinic has been perhaps a more advantageous place for research than the larger and more crowded clinics, where there is never time to establish such a personal relationship with patients.

Following in the footsteps of the Walworth Clinic, we began by advising mostly the Dutch pessary—though from the beginning we also advised the sheath, and later on we turned our attention to every kind of contraceptive. I usually showed the appliance to the patient, and sometimes drew a rough sketch to demonstrate exactly how the pessary was placed, and what it was designed to do. I tried to lead the patient by gentle

degrees to the knowledge that she would have to be examined by our doctor so as to have the right size, properly fitted. The working woman has a deep-rooted resistance against seeing the doctor on any account, and she is dismayed at the prospect of an examination. In some cases she shied off at this point and made some excuse for leaving—she had to consult her husband, etc. In most cases her fears were overcome and she was escorted to the doctor's consulting-room. The doctor herself always fitted the pessary in every case. Nurse helps to teach the patient how to adjust the pessary and to acquire skill and confidence in its use. Here again the patient is never hurried, and both doctor and nurse use infinite pains and patience. It can never be said that the pessary fails because of inadequate instruction. The patient is also taught the use of a douche if she has not already had experience.

The full instructions respecting the use of the Dutch pessary are rather complicated—certainly they must sound most involved to many of our patients, some of whom have never heard of birth control before coming to the Centre, and all of whom are lamentably ignorant of the physiology or functions of their own bodies. Many of our failures occurred amongst women who, though we *thought* they understood the technique perfectly when they left the Clinic, were nevertheless too frightened and too little confident of success to apply the method after they got home.

It was this disparity between our instructions and the actual behaviour of the women, this variation between our theoretically efficient organization and the delinquency

of our patients, and an obvious discrepancy between our experience and the printed experiences of others, that first led us to take a severely critical view of our work; to ask ourselves whether, in fact, birth control was working as well as we assumed, and as well as annual reports of most of the clinics and brochures from the few doctors who give instruction to large numbers of patients seemed to indicate. We drew gradually to the view that either our Clinic was unique and our patients were more stupid and careless than all others, or that all workers in the birth-control movement had allowed themselves to be deceived by a general impression of success derived from letters and visits from grateful patients. It is only natural that those who are most acutely aware of the need of family limitation, and of the terrible suffering which uncontrolled breeding entails, and who are pushing the spread of contraceptive knowledge against the obstructions set up by opponents, should eagerly wish to see their methods succeed, and should sometimes lay more emphasis on those happy cases where successful contraception has brought new hope and life to the patient, than on those unexplored cases which remain out of view.

Our scheme for dealing with patients was admirably comprehensive, but so much depended on the willingness of the women to co-operate. We could, for instance, instruct our patients to return for a second visit of inspection within a fortnight, and to come back for new appliances within at least six months, but in actual fact we found that a large number did neither. We could instruct our patients in the use of the pessary and the

douche until we felt certain they understood, and we could assume that they applied the instruction when they got home, but we only *knew* what had happened to those patients who of their own accord came back to the Clinic. Often we welcomed a poor overburdened woman, ill and depressed, terrified at the thought of another pregnancy, weeping as she told us her unhappy tale, and we sent her away cheered and hopeful, with a feeling of great satisfaction ourselves—the kind of case quoted in the annual report of every clinic. But it is another thing to *know* a year hence whether our advice has in fact proved a practical success or just a chimerical hope.

We followed the usual practice of all the clinics in writing to our patients at suitable intervals asking them to call again or to let us know how they got on. We never sent a printed form—always a personal letter, and in many cases we tried the experiment of enclosing a stamped and addressed envelope. But only a small number replied. Eighty-six letters were written in the course of this investigation, and only fifteen replies were received. And even some of these were too confused to throw much light on the woman's experience. What, for instance, can one make of this statement, taken from the letter of a schoolmaster's wife:

> I used my pessary, but my period came a week sooner than I expected and the pessary came away, so I felt a little nervous as to whether it would be effective and so I ceased to put any dependence upon it because of that reason.

We have received replies painstakingly scrawled on an

old envelope cut open, or a bit of brown wrapping-paper. The truth is that many poor women haven't even stationery to write on. And how can one hope that a poor woman, who has seldom put pencil to paper since her schooldays, who is harassed and overworked and overburdened from one week to another, who cannot always spare the price of a stamp, who has been brought up to believe, moreover, that sex and anything to do with sex is a shameful thing not to be discussed—how *can* one expect that such a woman will be able to put down her experiences and explain her emotions in writing?

Many women do write, just as many women do come back to the Clinic for repeated visits. But in both instances it is most likely to be the more intelligent and more successful cases. The failures must be searched out.

On this last point we find ourselves in complete disagreement with those who believe that it is safe to assume that most cases which are lost trace of are successful cases. In the main, our experience has been exactly the contrary. Women who have failed, either while using the appliance or because they couldn't use it at all, either feel ashamed to admit their failure or they shrug their shoulders and accept this as another disappointment to be added to life's misfortunes and patiently borne.

Dr. Marie Stopes, after pointing out that visiting the patients in their homes would be the only adequate method of gathering information, says in her report on the first five thousand cases at the Mothers' Clinic:[1]

[1] The First Report of the First Birth Control Clinic: *The First Five Thousand.* Pp. 49-51.

"In general, persons with a grievance are noisy, and those who are dissatisfied are immensely more inclined to come and register a complaint than are those who are satisfied to come and register gratitude. One finds the same thing in one's own life, where one complains at once if the milk is sour, but says no word of praise or thanks to the milkman who daily delivers fresh milk. One may take it, therefore, without undue optimism, that the greater number of the failures will either write or return complaining. . . . Of the five thousand cases seventeen returned, and were found definitely to be pregnant, fourteen others who reported in doubt were later visited and found to be pregnant, these together yielding a percentage of actual failures under one per cent., which compares to quite remarkable advantage with the percentage of failure of all other methods."

Percentages of this sort cannot be taken seriously as being even remotely accurate. Figures which are based on patients who have written or returned to the Clinic, and which ignore all the other patients who have been supplied with contraceptives, cannot give a true picture of failures or successes. As is pointed out in *Medical Aspects of Contraception*:[1] "Success is defined differently by different witnesses. In England and in America some consider that no further reports from patients mean 'all successes', although the 'non-reports' are from 20 per cent. to 50 per cent."

The extravagant claims made by protagonists of various methods led us from the outset—in the light of our own experiences—to suspect the validity of those claims, and

[1] P. 12.

the "statistics" which have been offered in support of those claims not only contradict each other, but are widely at variance with our own experience. The defence of rival methods has been conducted with a passionate intensity which the limitations and imperfections of all known methods scarcely seems to warrant.

CHAPTER IV

CONFLICTING EVIDENCE

IT must not be supposed for one moment that we consider birth control to have failed, or that we are unique in acknowledging that there has yet been no ideal method of contraception devised. Practically every writer on birth control points out the lack of a perfect method, and falls back on the universal statement that, defective as they are, present methods *are* being used successfully by thousands of men and women throughout the world. With both these points of view we are in agreement. But we believe that a scientific scrutiny of the data, if it were available, would prove (*a*) that the advocates of birth control have been more optimistic in their estimate of successes than the facts would warrant; (*b*) that the use of some methods—especially the pessary—is not as easy and simple as one is led to believe, and that many women who leave their clinic or doctor apparently well coached in the chosen method are in fact too frightened and uncertain to apply the advice on their own; (*c*) that many women fail, not because thay *have* used the appliance, but because they *cannot* consistently persist in its use—they are too weary and too harassed, they lack the leisure, the sanitary facilities, the privacy, and in many cases the stamina and intelligence necessary to success; (*d*) that there are many cases showing deformities or damage from too frequent pregnancies and lack of proper post-natal care for whom there is no effective contraceptive; (*e*) that present methods are failing almost

completely to reach the less intelligent men and women —the class whom it is most desirable from every point of view to restrain from propagating. There appears to be an alarming increase in mental deficiency.[1] This is too serious a national menace to be passed by lightly, or to be treated by palliative rather than prophylactic methods; and present contraceptives are not reaching these cases.

Our whole plea is, that though existing methods are without doubt being used successfully by large numbers of men and women, they are at best awkward and clumsy and uncertain, and in many cases impracticable and useless; and we should not be content, in a matter which so profoundly effects the health and happiness of every married couple, with contraceptives which *may* sometimes work in the case of normally constituted and intelligent people, and which admittedly frequently do not work in the case of the abnormal or deformed or injured woman, or in the case of the mentally dull and the woman who has become stupefied by work and poverty and excessive child-bearing. There has been no effective contribution to the technique of contraception in the past fifty years. We believe that the necessity and inevitability of birth control is now firmly enough established to justify a departure from the complacent acceptance of ineffective methods which has continued for so many years, and to justify a demand for a scientific exploration of the fields from which new and simpler methods may be expected to develop.

We have said that our own results, after following up

[1] See the Report of the Mental Deficiency Committee, Part IV.

the patients who have been instructed in contraceptives, are often at variance with the published opinions of others who have given contraceptive information to patients.

A doctor, under the pseudonym of Michael Fielding, has written a most admirable book on birth control.[1] But he seems over-confident when he says: "I wish to emphasize the fact that the methods are very easy to apply. Any person with average intelligence can adopt them with complete confidence. In any case, the practice of the method will prove to be much simpler than would appear from the description. I have never yet had a patient who has not mastered all the practical essentials of birth control in less than half an hour". And again, in the introduction of this excellent book: "Nothing is advocated that has not passed the test of experience and proved itself to be completely reliable as well as physiologically and aesthetically adequate."

We have been driven reluctantly to the conclusion that one cannot talk of "complete confidence" or "completely reliable" after one has followed up even a few hundred unselected cases. Can one be certain that the women who "mastered all the practical essentials in half an hour" applied the technique with continuous success afterward?

Mr. Fielding concludes: "On the whole, I think that this method of combining the use of a rubber pessary with a contraceptive ointment is the best available. . . .

[1] *Parenthood: Design or Accident?* London: Noel Douglas, p. 49. (The simplest, clearest, and best book yet published on birth control.)

The method is cheap, harmless, and, properly used, absolutely efficient."

The "properly used" is the central difficulty. It is easy to insist that whenever the pessary has failed it has not been "properly used". But our case is not so much that the pessary, if and when it *is* properly used, does not often enough succeed. The real difficulty seems to be that part or all of the routine instruction is sooner or later abandoned for various reasons which will be discussed later—reasons of sufficient importance to be taken into account when a simple and efficient contraceptive is under consideration.

Dr. Marie Stopes says: "Experience at the Clinic with 1,700 poor and uneducated women has shown that ten minutes' instruction is quite sufficient under ordinary circumstances".[1] In her very interesting report of the first five thousand cases[2] she considers that "There is not the slightest difficulty in contraception for the normal and healthy. . . . So far as we can discover not a single case of failure has taken place with an absolutely normal woman who conscientiously did what she was told to do." The real flaw is, of course, that Dr. Stopes has not discovered what has happened to all of the five thousand who have not returned to her clinic, whether they are normal or abnormal. Her results, as we have pointed out earlier, are based upon the cases that have come back, and the assumption that the others may be taken as successful cases.

Dr. Stopes thinks that "in nearly all our failures the

[1] *Contraception: Its Theory, History, and Practice*, p. 141.
[2] *The First Five Thousand*, pp. 31 and 52.

patient was abnormal in some degree, and most of them failed to carry out the instructions given to them by the nurse or doctor". She points out that about 5 per cent. of her cases have been the abnormal or injured woman, and that these present the greatest difficulty in the matter of contraceptives. Mr. Norman Haire, in a very clear and explicit little pamphlet, says: "If well-fitted and well-placed, it [the pessary] is a *sure preventive*."[1] The Medical Committee appointed by the National Council of Public Morals, in connection with the investigations of the National Birth-Rate Commission, concludes, after examining various witnesses: "It [some kind of pessary] is being used in increasing numbers, as it is the method advised in the birth-control clinics of this country, and in most of those in America. . . . Used as above, these appliances undoubtedly effect their purpose in the majority of cases."[2]

On the dust cover of *Birth Control*[3] we find the assurance that "In Vienna the methods described [the silver pessary] are being practised with complete success by the fifty doctors working in every district under Johann Fersch's League for the Protection of Motherhood."

We feel that it is not too much to ask that such unequivocal statements should be substantiated with much more definite proof than is as yet forthcoming. And this definite proof will not be available until the passionate advocacy of this or that method is replaced by a calm scientific approach. Take, for instance, the method advo-

[1] *Hygienic Methods of Family Limitation*, a pamphlet issued by the New Generation League, p. 10.

[2] *Medical Aspects of Contraception*, p. 6.

[3] *Birth Control*, by Johann Fersch, translated by Christian Roland and edited by Miss A. Maude Royden.

cated by Mr. Fersch and employed by numerous doctors in Vienna. The pessary—a small, basin-shaped affair of silver, made in several different sizes—is first fitted by a medical man. It is removed by the woman before the menstrual period, and must be replaced by a doctor afterward. After intercourse the patient must douche, but "it is not absolutely essential that this douche should take place immediately after intercourse, it can be done a quarter or half an hour later, *but on no account later*".

I visited Mr. Fersch and several doctors while in Vienna in an effort to gather some information about the success of this silver pessary. If the woman was obliged to return—and *did* return—once a month to her doctor, it would be the simplest thing in the world to gather indisputable month-by-month statistics of the woman's condition and the suitability of the pessary as a preventative. But I was not able to get one single figure beyond the continuously reiterated generalization that that method had been employed successfully for twenty-five years. Every question I put was regarded as a tentative criticism of the silver pessary, and was met by a passionate speech in defence of the method. I finally appealed to a medical man high in the municipal government. He did not know about records. Perhaps there were some. It had been successfully used for twenty-five years! He would see. He would inquire. He would send on statistics about the pessary. No records have ever reached me, and I am convinced that there *is* no adequate statistical evidence to be found in Vienna. At the Central Clinic, not even the name and address of the patient was taken. The organizers—charming idealists who had made

great sacrifices in the cause of birth control—prided themselves on wasting no time on machinery, but on pressing forward with the main business of spreading birth-control knowledge. Their *impression* was that their methods were working, and it seemed of no importance to them to establish that presumption beyond a doubt.

There was undoubtedly a time when the *idea* of birth control was new and startling, and had to make headway against much blind ignorance and superstition, when the most important thing was to concentrate on widespread propaganda. Now, surely the time has come when the most ardent champion of birth control for the masses can afford to take stock of the present-day position.

Before going on to a discussion of the Cambridge cases, it will be well, perhaps, to review briefly the most widely known methods, with especial reference to the confusing differences in technique advocated by various experts. Reference will also be made to the interesting figures drawn up both by Dr. Stopes and Mr. Haire concerning methods *previously* used by their patients. In this connection it must be pointed out that these figures do not represent the success or failure of the method advised at the Mothers' Clinic or by Mr. Haire, but only those methods which patients had already tried before applying to clinic or doctor for further instruction.

Only brief reference will be made to the actual methods advised at clinics and by doctors, as full details can be found clearly described in several works.[1]

[1] *The Comparative Value of Current Contraceptive Methods*, by Norman Haire; *Parenthood: Design or Accident?* by Michael Fielding; *Contraception: Its Theory, History, and Practice*, by Dr. Marie Stopes.

The clinics affiliated to the Society for the Provision of Birth Control Centres advocate chiefly the Dutch pessary—a hemi-spherical rubber appliance with a watch-spring in its outer edge, designed to lie transversely across the vaginal passage and interpose a barrier between the spermatozoa and the internal os. Occasionally the Dumas, a somewhat similar pessary, but without a wire spring, is used. The Dutch pessary is also the method advocated by Mr. Norman Haire, who was one of the earliest to introduce this method in England. Patients are advised to cover the pessary with a coating of contraceptive jelly of one sort or another before insertion, and to douche before and after removing the pessary in the morning on arising.

At the Mothers' Clinic Dr. Stopes advises the use of a cervical rubber pessary with a solid rubber rim, known as the Prorace pessary. It is designed to fit over the cervix, and it is claimed that it keeps its position by the action of suction. Dr. Stopes at first considered that "the cap alone, without any chemical, is in most cases safe and sufficient",[1] but it is now recommended in conjunction with greasy suppositories, generally quinine or chinosol.[2] Dr. Stopes does not approve of douching, but has been obliged to recommend it in 761 cases on medical grounds. She sometimes advises a sponge with quinine suppository.

Mr. Fielding considers a pessary, either of the cervical type or the Dutch pessary, to be the best method of contraception. The former, he thinks, can be more reliably

[1] *Contraception: Its Theory, History, and Practice*, p. 144.
[2] See *The First Five Thousand*, p. 36.

fitted by a woman who cannot have the advice of a medical man and must rely on applying the pessary herself, unaided; the Dutch pessary he considers simpler to apply in general, but quite likely to be unreliable unless fitted by a competent doctor in the first instance. He recommends a contraceptive jelly, and does not approve of douching.

In at least one Welfare Clinic where birth-control information is also given, reliance is placed entirely on a small quinine tablet, a Dutch pessary being used merely to hold the tablet in place near the cervix. Medical men in private practice appear often to recommend a soluble pessary alone, or the use of the medicated sponge.

The condom, or sheath, to be used by the male has not been in general use in clinics. Cambridge is, perhaps, the exception, where we frequently recommended the sheath in the beginning, and at the present time always urge it as the most reliable method in every case where the husband can be relied upon to use it faithfully.

We agree with Lord Dawson, who says: "In my opinion the male sheath and the use of soluble pessaries by the women are the most satisfactory methods of contraception at present available", especially if used in conjunction; we have never ourselves recommended soluble pessaries to be used alone. We would, in fact, endorse his statement that "if absolute security be desired, the only way of securing it is, in my opinion, by the use of the penile sheath."[1] The same view about

1 Address to the Medical Section of the Fifth International Neo-Malthusian Conference.

the sheath is expressed by Havelock Ellis:[1] "The condom is now regarded by nearly all authorities as, when properly used, the safest, the most convenient, and the most harmless method." Many private practitioners appear to advise the sheath when a contraceptive is called for.

The confusion existing in the field of contraceptives is nowhere more clearly demonstrated than in the conflicting views held concerning the condom, the necessity or advisability of douching, the necessity for removing the pessary very shortly, and the advisability of leaving it in position for some time, etc.

Dr. Stopes is emphatically opposed to the sheath. "Much hindrance to progress in contraceptive knowledge", she says, "has resulted from those advocates of control who ignore or deny the undoubted fact that there *is* truth in the contention of the clerical and 'purity' schools of thought that 'contraceptives are harmful'; for the condom is the contraceptive most generally known, and its recommendation by the medical profession has been weighty, and yet I maintain that it does do harm."[2] And of Lord Dawson she says: "So recently as 1922 he knew so little about the practical aspects of contraception that he advised only the old-fashioned methods of the sheath or the quinine pessary. . . . It is interesting to find that almost without exception every woman whose husband has ever used it detests it wholeheartedly, and that in 75 per cent. of those cases who used it before coming to the Clinic *it has failed*. . . . The compara-

[1] *Sex in Relation to Society* (1921), pp. xvi, 696.
[2] *Contraception: Its Theory, History, and Practice*, pp. 128–9.

tively small number of women coming to the Clinic whose husbands have used it is probably due to the fact that condoms are rather an expensive form of contraception".[1]

The Medical Committee appointed by the National Council of Public Morals concludes in respect to the sheath: "This is probably the most certain of contraceptive methods, but as its use necessitates intelligent care it is unsuitable for the ignorant and those under the influence of drink, while the cost makes it prohibitive for the poor."[2]

Mr. Fielding[3] thinks "that the condom suffers from a number of serious disadvantages. When in position it prevents the ideal contact aimed at between the man and the woman . . . it has, like the soluble pessary, the disadvantage of interrupting the flow of emotion between the man and the woman. Also the price is ridiculous."

Mr. Fersch[4] says that it has "the serious disadvantage that it often bursts in the decisive moment, and is therefore discredited now and for the future. The check pessary, in the form described [the silver pessary], is the *only* hygienic and good preventative worth consideration in avoiding conception. . . . Even if, here and there, cases occur in which conception takes place in spite of the use of the pessary, they are but few; the majority are safe."

Mr. Norman Haire thinks that "the rubber ones

[1] *The First Five Thousand*, pp. 43–44.
[2] *Medical Aspects of Contraception*, pp. 15–16.
[3] *Parenthood: Design or Accident?* p. 64.
[4] *Birth Control*, p. 70.

[condoms] diminish sexual satisfaction so greatly that most men object to using them, and some women find them actually painful".[1]

It is difficult to explain how this notion that the sheath is an expensive method has gained credence among so many people who ought to be able quite easily to find out the price. At our Cambridge Clinic we sell several kinds of washable sheaths at sixpence each; they are frequently used for three or four months, quite often longer. Just the other week an old patient came back for a new sheath after having used the original one for three years! Its cost was sixpence. No method could claim to be cheaper. The experience of our patients in using the sheath will be discussed in a succeeding chapter, when it will be seen how widely our percentages of successes and failures differ from those percentages given in the Stopes and Haire tabulations, which we shall presently discuss.

The same remarkable divergence of opinion is found when the question arises as to how long the pessary—of whatever kind—is to remain *in situ*, and whether or not douching is essential. This is a most important point, for the difficulty of douching has been one of our most serious problems.

Dr. Stopes's pessary "can be safely left undisturbed for twenty-four or forty-eight hours, and can be removed any time next day for washing or exchange. . . . As a rule the woman should take it out every second day at latest, and leave it out for some hours at least for cleansing

[1] *The Comparative Value of Current Contraceptive Methods*, p. 8.

before re-insertion."[1] It would appear, therefore, that the pessary may be safely left in place continuously, except for two hours every other day.

Mr. Fielding's instructions are: "The pessary may be left inside for forty-eight hours. After this it must be removed to allow any natural secretion from the womb to escape. It may, if required, be put back three or four hours after removal. . . . The pessary should never be removed in less than sixteen hours after sexual intercourse."[2]

The silver pessary of Mr. Fersch is, of course, to be left in place continuously, except during the menstrual period. But this particular method need not concern us here as it is not employed in England. It is mentioned as a further illustration of the diverse opinion that exists.

Mr. Haire thinks the pessary should be taken out the first thing on rising in the morning, and on no account to be left in place more than twelve hours. He thinks that douching is essential, and this is the view of the clinics for the most part. Dr. Stopes and Mr. Fielding both oppose douching. Some of the clinics using the Dutch pessary have attempted to dispense with douching because of the great difficulty this presents to the working woman, and the clinic which relies on the quinine tablet does not advise douching.

There is a wide difference of opinion, even among the doctors who have received a similar training at the Walworth Clinic, as to the size of Dutch pessary which should be fitted. Some use mostly sizes 60 to 70 mm., while

[1] *Contraception: Its Theory, History, and Practice*, pp. 144–146.
[2] *Parenthood: Design or Accident?* p. 58.

others tend to much larger sizes—70 to 80. Some private doctors habitually fit 50 to 60—sizes so small that we have never stocked them at all in our Clinic.

Enough has been said to point out the confusion prevailing in prescribing the technique of birth control—a confusion which is perhaps not too surprising considering that there is no instruction in contraceptives given to any medical student. These diverse opinions as to the correct technique of birth control would not be so important if the results were uniformly more successful. But there is just as much diversity of "opinion" as to what the results have been as there is in the matter of the contraceptives themselves.

The following comparisons of figures obtained by both Mr. Haire and Dr. Stopes are very interesting, but not as illuminating as could be desired. Patients who came to them for contraceptive information were asked what previous method they had used, if any, and how successful it had been. The figures, rearranged for the sake of uniformity, are as follows:

Method previously adopted.	Proportion of Failures.	
	Mr. Haire	Dr. Stopes.
	per cent.	per cent.
Condom or sheath . . .	51·14	75·25
Douching and syringing . .	73·5	95·16
Various cervical pessaries . .	87·5	85·48
Quinine suppositories . . .	70·8	98·18
Coitus Interruptus . . .	69·5	81·82
Safe period	100·0	100·00

Dr. Stopes based her figures on 1,284 cases and Mr. Haire on about 1,800. Both Dr. Stopes and Mr. Haire rightly point out that, as many patients asking for contraceptive information had tried something previously and failed, the percentage of failures above quoted is probably higher than would be the case if the figures could be based on an unselected group from the contraceptive-using public.

The disappointing thing is that there is no mention in either group of figures of the Dutch pessary, which has been so much under discussion as opposed to its rival, the Prorace cervical cap. Dr. Stopes says that "the term various cervical caps includes two or three forms of caps, the use of which I have always strongly deprecated, in particular the hard lens-shaped 'Dumas' cap and various faulty makes on the market". Mr. Haire apparently refers more particularly to the caps which may more properly be termed cervical caps—that is, they are designed to fit over the cervix rather than across the vaginal canal, as is the case with the Dutch. Dr. Stopes reports a failure in cervical caps of 85·5 per cent.—2 per cent. lower than that reported by Mr. Haire. Yet she claims only 1 per cent. failure in the Prorace pessary which she herself advocates—a pessary which varies only slightly in form and shape from the many other cervical pessaries on the market. Mr. Haire does not, apparently, bring forward any percentage of claimed successes in the Dutch pessary, nor do I know of any published figures in respect to this widely advocated pessary.

On the face of this evidence one might be justified in assuming that all users of the Dutch pessary found them

so successful that they did not thereafter apply for any further information. We shall be able to present a certain amount of evidence as to the use of the Dutch pessary in another chapter.

But the above figures point clearly enough to the crude and unsatisfactory state of contraceptive knowledge.

Neither the above figures nor the results we have achieved at our Clinic would justify, we feel, the conclusion of Dr. Stopes when she says: "Now that the subject has received so large a measure of public support and approval it is probable that advances in research and improvements in methods may be anticipated, although the practical difficulties of these researches remain very great, and are the less urgent as methods already available are sufficiently satisfactory for the majority of normal people."[1]

[1] *Contraception: Its Theory, History, and Practice*, pp. 332–333.

CHAPTER V

FOLLOW-UP WORK

THE cases selected for personal investigation were the first three hundred registered at the Cambridge Clinic between August 5, 1925, and May 24, 1927. The report on these cases, as was emphasized earlier, is not offered as conclusive proof that any method has failed or succeeded, or as conclusive proof that one method is better than another. It is offered as a painstaking and honest examination of each case, and a chronicle of the opinion of the women themselves as to the merits of the methods they have tried. It is extremely difficult to tabulate or classify the results, for the findings have been so complicated by individual idiosyncrasies. A general classification will, however, be attempted, and the individual cases will also be discussed.

No pain has been spared in an effort to trace and interview every case without exception. Sixty-two of the three hundred patients had moved from the address recorded in our files. I succeeded in tracing fifty-two of these, several of them through three or four moves. Ten have vanished from view, and my most persistent efforts failed to find them, though I followed up many clues.

Tracing patients who have moved is not an easy task, as the greatest discretion must be used to conceal any connection with a Birth Control Clinic. A great many patients come to the Clinic quite secretly, determined to conceal their visit from their mother-in-law or their grandmother, who disapproves of birth control, or from

their neighbour, who would be likely to broadcast the news. It has not been our experience, as it seems to have been at other clinics, that women discuss birth control with their neighbours and send their friends to the Clinic after they have been themselves. This happens sometimes, but in general the women show the greatest anxiety lest they shall encounter one of their neighbours at the Clinic, or lest someone living in their tiny court will send the news flying round that Mrs. A. has been to the Birth Control Clinic. We have made a practice of always asking the patient how she heard about us. Apart from the considerable number who are sent by medical men, the great majority read the advertisement, which appears every week in the newspaper, and come alone on their errand or at best with one close friend. "I keeps myself to myself", they say.

Despite my efforts at discretion I managed to stir up a hornets' nest in one village, where the wives of three brothers resided. It appears that there is no village large enough to contain three sisters-in-law, particularly when so delicate a matter as birth control gets mislaid amongst them. Mrs. A. had been to the Clinic secretly; Mrs. B. had wanted to come but couldn't quite summon the courage; Mrs. C. was bitterly opposed to birth control, and it was she, alas! who received a letter intended for Mrs. A. I drove out to the village and found Mrs. C. angry and explosive.

"She didn't ought to do such wicked things", she said of her sister-in-law. "She ought to trust in God the way I do." Two children were playing in the garden, and I asked her if she had any others. She had only two. "Do

you really mean", I asked, "that you trust in God, or is it that you trust in your husband? I suppose he is very careful."

She fell at once into my trap. "Yes," she said, "he's always been careful." I pointed out that *coitus interruptus* was one method, which she and her husband used, and that her sister-in-law preferred to use another method. But she maintained her ground about the wickedness of mechanical appliances. " 'Taint natural", she insisted, and one was reminded of the argument of the Roman Catholic opponents who have picked out restriction to the so-called safe period as their "natural" method. There was an angry scene in the market-place between the sisters-in-law, each of whom refused to own the letter. But all has ended happily, and now timid Mrs. B. is a patient at the Clinic, and her secret is being carefully guarded.

Altogether I made 331 calls in Cambridge, and in many little villages within a radius of twenty-five miles. Some of those sun-swept afternoons, when I drove about the leafy country lanes hunting out old patients, are delightful times to remember. Some of those dark evenings, wind and rain tortured, when I had to abandon the car and walk for miles along sodden, rut-filled cart-tracks, are not quite so pleasant to recall. Sometimes I would find in the end that I had been misdirected, and had come to the wrong farm-house. Sometimes, when I found the house, the woman herself would be in the fields at work, or gathering fruit from the orchard, or helping with the farm tasks. Then I would follow her over ploughed fields, through meadows, jumping ditches, scrambling

through hedges until I found her. And in these unconventional circumstances we would talk. Sometimes she drew me aside into the shelter of a shed; sometimes she took me to the house and invited me into a tiny parlour, where we talked in whispers because there was a sick child, or her husband was ill, or she had never dared to tell him of her visit to the Birth Control Clinic. Fear, shame, anxiety—the ever-haunting dread of another pregnancy; work, toil, pain, weariness; crying babies; washing, cooking, scrubbing; nursing the sick, carrying water; no rest, no relief, cut off, isolated; patient, suffering; denied all joy, all beauty—slaves if ever slaves there have been—can anyone deny the right of one of these women to rebel against this ever-increasing burden of unwanted children? Can anyone deny her need of some contraceptive which she can use despite all her work and weariness, and on which she can absolutely rely? Yet for many of these women there is no suitable and certain contraceptive at all. They go on conceiving children and pray that a merciful Providence will bring about a miscarriage.

Of the first three hundred patients, 36 were known or suspected to be pregnant on their first visit, or (in the case of a few) became pregnant between the time when they first came to the Clinic and the time when, on a later visit, they received contraceptive information. Only eight of these voluntarily came back after the birth of their babies for contraceptive advice; thirteen others also came back after I had called upon them. Five never returned and were never advised; and nine who were given advice on their first visit, because the condition of

pregnancy was very uncertain, never subsequently came back for further instruction. In all, eighteen of the pregnant cases returned for advice after the birth of their babies.

Even so simple a thing as a visit to the Clinic is an event of great importance in the lives of some of these women. Some have to walk miles from a remote farmhouse before they can reach any kind of conveyance. Others must wash and dress and bring along three or four young children, and get back home in time to look after the older ones when they return from school. The mere undertaking of getting to the Clinic requires more effort than many weary women seem able to make. When the awful suspicion of an unwanted pregnancy is upon them, they rush in panic for help. At other times there is always the possibility that they may escape pregnancy, and they "take the chance".

Six of the first three hundred patients came to us because they eagerly wanted children. Two of these were referred to the hospital for slight operations, and each is now the happy mother of a daughter. A third was medically advised and became pregnant, but unhappily the baby was still-born. The fourth was referred to the hospital, where she was found to be suffering from tuberculosis of the Fallopian tubes, and a radical operation was necessary, which has removed all hope of the so much desired second baby. But her husband is full of gratitude to the Clinic doctor through whose offices the disease was discovered at an early stage, and much more serious consequences thus avoided. The fifth is reconciled to the likelihood that no child will be possible owing to the age

of herself and of her husband. The sixth is, perhaps, the most pathetic case of all.

She came to us in September 1926, and was advised to go to the hospital for curetting. She returned in October 1927, and the doctor gave her the hope that she was probably pregnant. She came again in December, and symptoms of pregnancy had increased, the doctor's report showing enlarged abdomen and breasts. In January 1928 she paid us another visit in a state of happy expectation. She had had some sickness and, moreover, she had felt the movements of her child. We heard nothing more from her, and in the late summer I called at her house. She had never been pregnant at all—all the symptoms had apparently arisen from her ardent wish to convince herself of pregnancy. She showed me the white cot and the little garments she had so joyously made ready. Finding consolation for childless women is not the least difficult task of a Birth Control Clinic.

Fourteen patients registered who did not receive advice. Five of these evidently came out of interest or curiosity and never intended to avail themselves of contraceptive instruction. Three believed themselves to be pregnant, but were, in fact, entering the menopause, and so considered themselves to be beyond the age for contraceptives. One thought she and her husband would prefer to continue *coitus interruptus*, which they had always practised, and by which means they had succeeded in keeping their family down to four. Three were women of limited intelligence. They had twenty-three children amongst them, and had not enough stamina to undertake anything new. One, I learned later from her neighbours,

had given birth to her eighth child since visiting the Clinic. This last confinement nearly cost her her life: she had been for many weeks in a charitable convalescent home, and her seven children were being supported by public funds in the infirmary.

Another was too shy and timid to see the doctor. She had previously bought a Prorace pessary, but didn't know how to use it. She had used quinine pessaries with success for some four years between her third and fourth child. But she couldn't "always afford half a crown for a box when she needed them". She had her fifth child after visiting the Clinic, and now, following a period of eight months of complete abstention, the husband is using a sheath purchased at a chemist's shop. The wife's fear that some of her neighbours will learn about her efforts at family limitation is so acute that she prefers to get a more expensive sheath at a chemist's shop rather than to be seen coming to the Clinic.

The last of this group who did not receive advice is a pathetic little woman, wife of a farm labourer. She lives in a tiny, spotless cottage miles from the main road, and she never sees anyone except her six small children and her husband. She is thirty-four, but she looks fifteen years older, though there are still traces of a youthful beauty about her. Her husband "doesn't believe in birth control" and will not allow her to take any steps to limit her family. She has had one baby since visiting the Clinic.

Three patients were registered who did not receive information, but whose general condition called for medical attention. One underwent a major operation at

the hospital, and is now greatly improved in health. One of the others had a large fibroid tumour removed, and has since well recovered.

At the present time, no patient is ever registered at the Clinic excepting those who intend to apply contraceptives, so that now the Clinic cards represent only actual patients.

We may summarize the patients among the first three hundred who never received contraceptive advice as follows:

Patients who wanted advice about having child . .	6
Patients whose general condition was treated . .	3
Patients who were pregnant, received no instruction, and never returned	5
Patients who came through curiosity, or who wanted first to consult their husbands, etc.	14
Total never receiving advice . .	28

Twenty-five patients have been definitely lost trace of. Of these one came from Coventry, one from Yorkshire, one from Winchester, one has gone to Morocco, one to Scotland, and the others are for the most part scattered in towns and villages too far away to be reached in person. They have all received letters, but none has replied. Of these twenty-five we know that two used the sheath with success for a period of one year; one who took a sheath gave birth to a child the next year; and two used the Dutch pessary with success for one year. But these figures are not included in the general report because the patient could not be traced after the investigation of the first three hundred was begun. So we have:

Patients receiving contraceptive advice in the first 300 .	272
Lost trace of and no reply to letter	25
Cases about which result of contraceptive is known	247

As we have already mentioned, we would not presume to discuss this small number of cases as showing any special significance if we were able to set them all down as successful cases, or even if the number showed a small proportion of failures. But we are obliged to record (as will be detailed in the next chapter) 78 cases of undesired pregnancy (amongst 75 patients), and 80 patients who, for many reasons which will be discussed later, abandoned the use of a contraceptive, but fortunately have so far escaped pregnancy. It is a significant indication of the limitations imposed by present-day knowledge of contraceptives when 155 people out of 247 are obliged to admit that they found methods of family limitation either so ineffective or so distressing or so troublesome that they abandoned the attempt to use them.

As will appear in an ensuing chapter, many of these patients who failed in the first instance with one method have since been induced to try another. Eventually, it is hoped that by this method of trial and error some of these can be classed as successful examples of conception control. But the field of "trial" is extremely limited, and we have already had the experience in some difficult cases of coming to the end of everything we can suggest.

We may be criticized by some for classing amongst "failures" pregnancies which occurred because the women could not apply the contraceptive recommended. But in view of the pressing need for some method which

can be applied, especially to the difficult cases, we feel justified in classing as failures all pregnancies occurring from any cause whatever after contraceptives have been prescribed, except in cases where the contraceptive was deliberately abandoned to bear another child. And because the need is so great, we feel justified in pressing once again for scientific investigation in the field of contraceptives.

CHAPTER VI

FAILURES

WE come now to a discussion of the cases of unwanted pregnancies occurring amongst these 247 patients since they visited the Clinic, and a review of those (80) other cases who abandoned the use of the contraceptive, but have not yet become pregnant. Altogether, including those pregnant on their first visit to the Clinic, there have been 123 cases of pregnancy. Thirty-six of these have already been mentioned as having occurred before the patient received contraceptive advice; three occurred amongst patients definitely seeking advice about having a child; and 6 amongst patients who gave up the contraceptive they were using in order to have another child. So there remain 78 undesired pregnancies among the 247 patients. These figures may be summarized as follows:

Total pregnancies (from time of first visit) including cases pregnant on first visit		123
Pregnant on first visit and before contraceptive advice	36	
Pregnant after seeking advice about having child .	3	
Pregnant after giving up contraceptive to have child	6	
	—	45
Total unwanted pregnancies after receiving advice		78

These 78 unwanted pregnancies were distributed among 75 individual patients as follows:

72 patients had one pregnancy: aggregate pregnancies		72
3 patients had two pregnancies: aggregate pregnancies		6
75 patients	aggregate pregnancies	78

Among these 78 pregnancies, 16 occurred while the patient claimed to have been using the pessary as directed, including the douching before and after its removal in the morning; and three occurred because of some fault in the sheath. Three others may be classed as partial pessary failures, inasmuch as they used the pessary but did not douche. Some authorities, as has already been pointed out, advise against douching. One of these three was accustomed to leave the pessary in place for several days at a time. (It is interesting to note that one of our successful pessary cases follows exactly this same plan.)

Two of the 16 pessary cases may be classed as super-failures, inasmuch as they not only used the pessary as directed, but douched *immediately* after *coitus*. One of these became pregnant on the one occasion when she failed to rise and douche at once, although she was following out all the directions given her at the Clinic. The first mentioned of these two has a history of seven previous pregnancies.

Four of these 16 patients I considered not to be very intelligent, and I had a general suspicion that they had probably not carried out full instructions. However, they stuck to their story through all my questions and suggestions, so that they must be classified among the real failures for lack of evidence to the contrary.

One of the 16 became pregnant before coming back for her second visit, but our records show that the pessary fitted well, and that she appeared to understand its use. She blames the Clinic for her failure, because if she had not been relying on the pessary her husband would have been "careful". It is true that three children were pre-

viously conceived while the method of *coitus interruptus* was being employed; but the couple have gone back to this method, considering it to be more reliable than the pessary.

One of the failures was the case of a young wife who had previously borne two children by Caesarian section. She was sterilized at the time of her third delivery. Another was a young woman who is completely paralysed in the right side. This infirmity may have made it difficult for her to place the pessary properly and to douche effectively. She had previously had five pregnancies with three living children.

One of the patients who failed had previously had four pregnancies, resulting in one miscarriage and four children (one set of twins). One, thirty-eight years of age, had a record of nine previous pregnancies, including one miscarriage and eight living children. Her husband earns £2 a week. Another had a history of eight previous pregnancies with six living children and two miscarriages. The last pregnancy also resulted in a miscarriage at three months. The failure of the pessary nearly cost the life of one patient, who had a serious miscarriage at four months. She spent eight weeks in bed.

Of the three who became pregnant though their husbands had used the sheath, one case alone seems inexplicable. The other two took definite risks against which they had been warned at the Clinic, by using the sheath over too long a period. One couple had used the same sheath seven months and the other twelve months. One of these was the case of an epileptic who had been warned against any further pregnancy. An unexplained failure in

the case of an old sheath or pessary, which still appears to be in good condition, leads one to speculate whether the rubber may not in time become so thin as to be porous to microscopical matter like spermatozoa while it yet appears to be unaffected in the course of an ordinary inspection.

It must be evident even in this brief review of these few failures, how serious a business one unintentional pregnancy can be. And this will be even more evident, perhaps, when we discuss the failures resulting from the inability of the patient to use the pessary. Many of these cases were patients sent to us by doctors who considered that a further pregnancy would impair the patient's health or be a positive danger to her life. The very fact that a woman has suffered ill-health or injury through previous childbirth makes it all the more difficult to apply the existing methods to her case, and all the more necessary that some reliable method should be available for her.

Forty-two patients became pregnant because—for almost as many reasons—they gave up either part or all of the procedure considered essential to successful use of the pessary; they either abandoned the pessary outright or they gave it up at certain times and used it at other times. Seventeen became pregnant because their husbands could not or would not use the sheath.

It will, from this point on, become increasingly difficult to assign cases to definite categories and classes, and the reader who has a passion for making every set of figures arrive at a proper and satisfactory total must be warned of difficulties ahead. The difficulty will increase still more when we attempt to assign credit to any given method for

successful avoidance of pregnancy; for here it is often several methods alternating that have been used, or several methods simultaneously. In many cases where the first method proved unsuccessful, another method later proved satisfactory.

Some of the reasons given by patients for abandoning the pessary or sheath are simply frivolous or stupid and merit scant sympathy. But our sympathy must still go out to the unhappy children who are conceived under these circumstances and who are quite as likely as not to inherit the feckless nature of their parents. Several men simply "didn't trouble" to use the sheath. One of these said he and his wife would take "pot luck" in this important matter of creating new lives. One used a sheath until it got thin, and both he and his wife were too feckless to get another. He relied on *coitus interruptus* and his wife became pregnant—the third pregnancy resulting from this method. One woman used a pessary until it got thin and then gave it up; two others broke their pessaries after some months of use and did not send for another.

In a few cases the husband refused to use a sheath himself, or to allow his wife to use a pessary. These few cases were men of low intelligence—one of them was certainly mentally deficient. He had also suffered severe shell-shock during the war. His wife is under thirty years of age, very tiny and frail, and she has given birth to another baby since visiting the Clinic—her seventh. The husband is a labourer more often than not unemployed. She herself is too dull-witted to be able to understand that she ought in any case to use the pessary with which we supplied her. The same is true of another

woman who is pregnant for the thirteenth time. She indignantly repudiated my suggestion that she ought to protect herself from further pregnancies whether or not her husband approved.

Amongst the 42 who gave up the pessary, 4 could not use it because of serious damage in previous childbirth. Two of these were compelled to wear a ring pessary for medical reasons, one suffered from prolapse of the uterus, and the other was under constant treatment for ill-health resulting from fourteen pregnancies. A considerable number of the others who gave it up because they found it very unpleasant to use or disliked it very much must be classed among the medical cases for whom there is no suitable contraceptive at the present time. Eight gave up the pessary because it hurt either the wife or husband or both, and here again, in most of these cases, an abnormal condition of the reproductive organs can account for this pain and discomfort. One found that her periods recurred every three weeks throughout the time that she used the pessary; 1 gave up because of "bearing-down" pains which she assigned to the pessary; another because the pessary made her "insides ache". A considerable number had "no confidence" either in their ability to place the pessary properly or in the pessary as a contraceptive agent. As many more "couldn't get on with it"—the douching was too difficult, the whole ceremony required more leisure and assurance than they could command. Several were afraid of injuring themselves, or the husband was afraid that the pessary would be pushed too far up, or that it would get lost in the body. One intelligent patient, wife of a professional man, was extremely

nervous whenever she tried to use the pessary, and on one occasion she became acutely distressed when she could not remove it. Another had to give up the pessary which caused acute pain from haemorrhoids.

Another very serious difficulty is connected with constipation—a malady which seems to afflict nine-tenths of the workers year in and year out. One of our most pathetic failures occurred in the case of a woman of very frail and delicate health who had borne five children in six years and gone through one miscarriage as well. She used the pessary faithfully, but found it impossible to get it in place during the mid-month between her periods because of constipation. We supplied her with soluble pessaries for this period as being better than nothing at all, and the doctor prescribed for the constipation; but she had apparently been accustomed to taking medicine for many years, and nothing seemed to have any lasting effect. Her husband is a labourer, and brings home a sufficient sum to keep the family from actual starvation. But the diet is necessarily very limited, and there is never any fresh fruit of any kind. *Coitus* takes place nightly, and on one occasion when she had run out of soluble pessaries her husband relied on *coitus interruptus*, with the result that she has now produced her sixth living child. She is grateful to us because we helped her to achieve a three-year interval between the sixth and the seventh pregnancies, whereas previously a child was born every year. Now all the children are able to walk, while she pushes only the last one in the pram. Previously she always had two or more in the pram stage at once. They are lovely children, beautifully cared for; but the mother is so thin

and white and ghost-like that it seems incredible she should be able to walk at all. Her husband will not use the sheath.

One of the greatest difficulties—and one which seems insurmountable—is the question of douching. The medical officer at Cambridge has considered the possibility of advising the use of a pessary without douching, but has concluded that neither our own experience nor such experience as one can gather from others would justify us in this step. Our general inclination is to amplify the present system with further safeguards rather than to eliminate one of the existing safeguards.

The vast majority of our patients have no bathroom or any suitable sanitary facilities for douching. In many cases they share a single out-door lavatory with lodgers or another family. They live in tiny, overcrowded houses, and more often than not share their bedroom with several children. The woman has no place in the house where she can go in privacy and be alone, much less where she can prepare and administer a douche. In cases where the children have all reached school age it is not so bad, but even here pressure of work makes the mother reluctant to spare the necessary time. "Sometimes it's night-time before I can get to it", one tired mother told me. Another, who finally gave up trying to use the pessary, said: "Many's the morning I've come down in my slippers before daylight so as to try and get it done before the children were up. But one of them always heard me, and then they were all at my heels." Another, who gave up the pessary after several successful years, did so because of the douching difficulty. Her husband had

fallen out of work, and she had succeeded in getting a job as "bedder's" help in one of the colleges. She had to get to her work early in the morning, and she had all she could do to get the children off to school before she had to start out herself.

Even the simple matter of hot water, which more fortunate women take for granted, is a difficulty for the poor woman. She may get up early before the family to try to get this task finished before they are up, but she must face a cold house, and she has only cold water until she can get the kitchen fire made. It is small wonder that so many women try to use the pessary without douching, or that so many give it up altogether.

One of our patients reported a rather unusual result from douching. She suffered intense pain in her legs immediately after douching, so that for some hours she could hardly climb the stairs or move about to get breakfast for her menfolk. She is a very intelligent woman, and after her husband had used the sheath for a time—a method which he found unsatisfactory—we suggested that she should try once more and see what effect would be produced. The result was the same, and she eventually had to abandon the pessary entirely.

Another patient complained of very great lassitude and exhaustion following the use of the pessary. She could not be certain whether the pessary alone or the douching was responsible. After a considerable period, during which the couple relied on *coitus interruptus*, we induced her to try the pessary again, and this time there appeared to be no recurrence of the previous symptoms. She had just started on her second attempt to use the pessary when

this investigation took place, so that the ultimate results are not yet known.

One of the failures in this group of cases is typical of the difficult case for which there seems as yet no remedy. The woman came to the Clinic because she suspected pregnancy. Her condition was doubtful, and she was given a sheath for her husband to use in the interval in case the suspected pregnancy did not develop. The pregnancy unhappily was soon verified, and the woman gave birth to her seventh child—her history also included one miscarriage. Since then she has again become pregnant. Both the last two conceptions occurred in the intervals when her husband was allowed home from a Mental Hospital. He was once more detained at the Mental Hospital when I called on our patient, but she was expecting him home shortly. The woman herself is too unintelligent to use a pessary.

Another of our patients explained that pregnancy resulted because she was "taken by surprise" on one occasion. She was never certain whether the pessary was going to be needed, an objection which has been voiced against the pessary by more than one patient. This difficulty is even more marked at the present time when we recommend the use of small quinine tablets in conjunction with the pessary as an extra safeguard. The women hesitate to use a tablet (they cost 1s. 6d. for 20) unless it is necessary, and a few sensitive women have told me that they found this uncertainty very upsetting. Their sensitiveness was, of course, a part of the stupid tradition in which most women, even of the present generation, have been brought up—the belief that sex is a subject on which

women should have no views and no sentiments—that intercourse is a necessary evil of marriage, but that, of course, every decent-minded woman would choose to avoid it if she could. The mere preparation by the use of the pessary seems to some of them an unwomanly invitation to pleasures which are supposed to have been designed for her husband alone, and in which she is supposed not to have any share or any interest.

We must honestly admit that there are very few indeed among patients at the Clinic who *like* the pessary as a method of contraception. Even those who continue to use it with successful results often dislike it and resent the bother it entails. Many have found the contraceptive jelly with which the pessary is coated before insertion either irritating or very messy and unpleasant. One of our patients—not amongst the first three hundred, however—found the contraceptive ointment so repulsive that she determined to use the pessary without it. She continued to do everything else as advised, but pregnancy ensued. We have tried different kinds of quinine and lactic acid ointments in an effort to find something satisfactory, but the messiness remains.

Many of those who tried and had to give up the pessary have taken sheaths for their husbands. In some cases the sheath has proved just as painful as the pessary, either to husband or wife, and has been abandoned. In some other cases it was too thick and heavy, but when later replaced by a thinner kind it was used with success. In many cases the sheath—like the pessary also—was used only when "something was likely to happen"—that is to say, the couple relied on *coitus interruptus* or on the so-called

safe period at certain times. This method accounts for several of the pregnant cases. One of the sheath failures was the case of a young couple who gave it up because it hurt the wife. She was very young and already had four children. After giving up the sheath her husband relied on *coitus interruptus*, and pregnancy occurred. The young wife wept as she talked to me, not so much because she was pregnant again as because the neighbours had been cruelly taunting her husband with lack of consideration for his wife. The couple had often continued without *coitus* for four, six, or eight weeks, but, despite their care, babies were continuously arriving. "Seems like it happens automatically", she complained, and I was reminded of an essay of a Cambridge undergraduate who bewailed the lack of thrift amongst the workers, and concluded: "It is of no use to do anything for the working classes. They just go on breeding automatically." There have been moments in the course of this investigation when I felt inclined to agree with him.

The reasons for the pregnancies in cases where the sheath was abandoned are in the main: (1) The husband was careless or indifferent and failed to use it always. (2) It caused pain either to husband or wife. (3) It seriously interfered with the pleasure of husband or wife, usually the former. Many husbands have made an honest effort to use the sheath and have found it impossible to do so. We have a few cases where the couple continue to use the sheath because they consider it the safest method, but it deprives the wife of all sensations of pleasure. (4) The couple had no faith in it because they knew friends who had been "let down" as a result of the

sheath splitting. (5) It wore out and another was never secured.

It may be argued that we are classing as failures cases in which the prescribed technique was not followed out, and that this does not present a just picture of the merits of the contraceptives under discussion. It would certainly seem, for instance, that when so simple a thing as replacing a worn-out appliance is concerned there can be little excuse when it is not done. Yet even here considerable allowance must be made for difficulties which would not exist in the case of an educated woman living in comfortable circumstances, but which are real and serious in the case of the very poor woman. We have already mentioned her reluctance—in many cases her inability—to write, and she is restrained also by her fear that the postman might guess what her letter contained if she sent for an appliance. This taboo on matters of sex and birth control is a tremendously powerful force, and its influence on the lives of the workers, particularly women, must be understood before they are condemned for what often appears to be undiluted stupidity. They are afraid to write on this subject, and the same timidity often influences them in postponing a visit to the Clinic for weeks on end. In the winter, too, bad weather and a succession of sick children sometimes frustrates for weeks their plans to return for a new appliance. And many of our country patients must walk or bicycle for miles in order to reach the Clinic. Ignorance and fear, more often than not reinforced by poverty and overwork, must be reckoned with before the woman is condemned as feckless and unworthy of further sympathy. One of our patients who failed to

renew her pessary in time to avoid another pregnancy has five children under six years of age. She must take them all with her whenever she goes out, which is seldom.

Apart from this small class of patients who used an appliance successfully until it perished, and then failed to replace it in time, there are very few indeed of those who have given up the use of the appliance whose reasons do not deserve serious consideration. We feel that a contraceptive can be legitimately classed as a success only when it has actually been used with success over a considerable period of time—that is, when it has not been so difficult or painful or obnoxious that the patient had to give it up, and when it has definitely prevented conception. And we feel that, in general, the other cases must be classed as failures whether that failure occurred when the appliance was being properly used, or after it had been given up either because the patient's condition was not sufficiently normal to permit of its use, or because the appliance caused pain, or because the patient found it so distasteful that she could not continue, or because she was too nervous and frightened to use it and had no confidence in it, or even because she was too stupid to apply it successfully. For surely the essential condition of a successful contraceptive is that it should be capable of preventing conception without interfering with the normal relations between husband and wife, and be simple enough in its technique to be used by even a dull and stupid woman, under the normal conditions to be found in a working-man's home.

Here we have 247 patients whose experiences over a

specific period are definitely known. We have 78 unwanted pregnancies (among 75 patients). And we have 80 further patients who for one reason or another gave up the appliance, but who have not since become pregnant; of these 65 abandoned the pessary and 15 the sheath. So that out of 247 patients we have 155 who, after trying the pessary or sheath, found it too difficult, too painful, or too uncertain to continue.

These figures deserve further analysis before the patients they represent are all classed as complete failures from our point of view. For in many cases, after a failure occurred with one method, or the method was given up for one of the various reasons already noted, the patient turned to another method and found it successful. In the main, this change over has been from pessary to sheath, and we have every reason to hope for more successful ultimate results than can be shown in the present report.

A small proportion of the 80 patients gave up the method for reasons which would remove them from the "failures" class—20 in all. These cases may be summarized as follows: 6 had passed through the menopause; 3 lost their husbands through death; 2 were sterilized in the course of operations; 2 were separated from their husbands; the husband of 1 had become an invalid; and 6 preferred complete abstinence to the use of any contraceptive. In the case of the last group, of course, it is possible that if a contraceptive sufficiently simple and certain had been available, abstinence, with its attendant strain, might not have been selected as a method.

I have attempted a general classification of the reasons

given by the remainder of the 65 who abandoned the pessary, but have not since become pregnant, under the following headings:

(1) 16 because they had no confidence in the appliance.
(2) 11 because it was too difficult.
(3) 7 gave it up because it hurt either husband or wife.
(4) 4 because they disliked it too much to use it.
(5) 4 because they were too tired and had no time to douche.
(6) 2 because they feared injury would result.
(7) 1 because it caused haemorrhoids.
(8) 1 because she became crippled with rheumatism.
(9) 1 because it made her feel "queer".

A small number use the pessary sometimes, but rely mostly on *coitus interruptus*.

Of the 65 under discussion who abandoned the pessary but have not become pregnant, 28 preferred to rely on *coitus interruptus*, 20 have turned to the sheath, 1 relies on douching, and 1 on Semori tablets—a soluble tablet we have recently placed on trial at the Clinic. It expands in contact with moisture and forms a jelly-like barrier as well as being a chemical deterrent. The remainder take no precautions.

The reasons given by those who abandoned the sheath are fairly similar: either husband or wife found it painful, the husband disliked it and refused to use it, or they had no confidence in it.

The "turnover" figures among these 155 patients who failed to use with success the method we first advised are interesting. Of the 120 women who either became pregnant while using the pessary or gave it up for some reason, 36 have since turned to the sheath as a method, 39 rely on *coitus interruptus*, and 2 are giving the pessary a second trial; of the 35 who had been supplied with the sheath but failed with it or gave it up, 1 has turned to the pessary and 10 prefer to rely on *coitus interruptus*. Some of the remainder are trying another kind of sheath, some take no precautions, etc.

Every type of patient is represented in this group we have been discussing. Naturally, those who most readily give up because the contraceptive is troublesome or difficult are usually the more stupid and feckless kind of women. But the group includes many earnest, intelligent husbands and wives who are seriously concerned about the responsibility of bringing children into the world for whom they cannot adequately provide, and whose advent means less of comfort and care for the children already born. It is our belief that prudent couples ought to be encouraged in this responsible attitude toward future citizens, and that there ought to be available for them a contraceptive simple and effective enough to guarantee them against chance pregnancies. As for the dull and stupid and feckless—can we, in the interests of the race, afford to encourage them to breed? Are we justified in dismissing them with a shrug of contempt when they do not use the methods we provide? The time surely is not far distant when it will be not only desirable but absolutely necessary to cut off the supply of feeble-minded

and mental deficients, as far as possible, at the source by adequate methods of contraception, instead of spending the hundreds of thousands now used every year to maintain these unfortunate children and to attempt to educate them into possible C_3 citizens.[1]

[1] See *The Problem of Population*, by Harold Cox, pp. 124-156.

CHAPTER VII

SUCCESSFUL CASES

WHEN we come to the cases which we shall class as successful, we encounter real difficulties in attempting to deal with figures and categories. For the experience of so many of our patients has included attempts to use several methods. In some cases one method failed and another was afterward used over a considerable period with success, so that the patient is both a failure and a success. In some cases a method was used with success over a considerable period and then abandoned because of some change in circumstances, as, for instance, the case of the woman who could use the pessary so long as her husband remained in work and she could stay at home, but who had to give it up when she was obliged to become the breadwinner herself and start to work early in the morning.

Similarly, pregnancies have greatly complicated the orderly arrangement of figures. If the patient suspected pregnancy, or was pregnant at the time of her first visit, so that she was given no contraceptive, we might not see her again until I visited her at her home, or until she "had another scare" about pregnancy. In some cases, owing to the reliance that some women place on suckling their last child as a precaution against a further pregnancy, eighteen months or two years might elapse before we got the patient back to the Clinic and actually gave her contraceptive advice. So though she was registered among the first three hundred she might have had less than six

months' experience with any method at the time of the investigation.

The first three hundred were registered at the Clinic within slightly less than two years from the date of its opening. But we followed these cases up to the end of 1928, so that we can give a total experience of nearly three and a half years.

I have therefore arranged six categories in units of six months, all trials of less than six months' duration being excluded. Into these categories I have put all patients who have used any method or combination of methods with success for a period of more than six months. This, of course, refers only to methods used at the Clinic and not to previous methods, which are discussed elsewhere.

The table will not give a clear picture of the actual successful experience with the various methods unless several facts are borne clearly in mind. In the first place there are more than five patients who have used the sheath with success for a period of thirty-six to forty-two months. But they began by using the sheath in conjunction with soluble pessaries and later used the sheath alone, or they began with the sheath alone and later supplemented it with the soluble pessaries or some other method. In each case the experience is separated and placed in those columns indicating the exact period during which each of the methods was employed. Many of the cases appearing in the table used an appliance for some period of time above six months and then failed or gave it up. But their total successful trial before the failure is placed in the appropriate column, and their

successful experience—if any—subsequent to the failure, is recorded, provided it covers more than six months. In every case where a deliberate pregnancy intervened I have deducted approximately ten months from the total experience, so that the figures represent, with as much accuracy as it is possible to attain, the actual period of time during which any given method was employed. If a patient used first one method and then another, each experience is recorded in the appropriate column.

For instance, one of our patients used the pessary over a considerable period of time, but at the beginning of last winter her husband decided to use the sheath so as to relieve his wife of the douching difficulty on the cold winter mornings. This patient's pessary experience is recorded, but her sheath experience, which is less than six months, will be discussed under a separate heading. Another patient tried the pessary a few times, didn't like it, and turned to the sheath, which her husband used with success for three years. Then he grew tired of it, and at present they depend on *coitus interruptus*, as they would not be unhappy now to have another child. Her few attempts to use the pessary are not recorded in the table, but the sheath experience is recorded over the appropriate period. The fact that the pessary was abandoned for the sheath, and the sheath for *coitus interruptus*, has already been noted in a previous chapter.

The numbers using the sheath or pessary, or a combination of the two, or in combination with soluble pessaries, are as follows:

SUCCESS FOR SPECIFIED PERIODS OF TRIAL OF SPECIFIED CONTRACEPTIVE METHODS

Contraceptive.	Period of Trials (in months).					
	6–12	12–18	18–24	24–30	30–36	36–42
Dutch pessary.	19	24	8	10	5	3
Dutch + sol.[1] or Q tablets[2]	—	1	—	—	—	—
Dutch or sol. .	—	—	—	1	—	—
Sheath . .	15	15	15	11	5	5
Sheath + sol. .	1	—	1	1	—	—
Sheath or Dutch	—	3	3	3	—	—
Sheath + Dutch	—	—	1	1	1	—
Dutch + douche[3]	—	—	—	1	—	—
Dumas pessary .	—	—	1	1	—	—
Prorace pessary .	—	—	—	1	—	—
Contraceptive ointment alone	—	1	—	—	—	—
Total . .	35	44	29	30	11	8

[1] Sol. = soluble pessaries.
[2] Q tablets = Quinine and urea tablets.
[3] Douching immediately before and after *coitus*.

It will be seen that 75 have used various types of pessary alone or in combination with soluble pessaries during all the periods considered; 69 have used the sheath alone or in combination with solubles, while 12 have used either or both Dutch pessary and sheath. The figures would appear to contradict our previous inference that the sheath had been a more successful method than the pessary. But several facts must be remembered. In the first place, though we recommended the sheath in

cases from the day the Clinic opened, we tended to recommend the Dutch pessary much more often during the early days of the Clinic. So that the Dutch pessary had a potentially longer period of trial amongst a larger number of patients.

All the pessary and sheath failures are included in this table if they had a previous history of successful use for more than six months. And there were more pessary failures than sheath failures. It will be remembered that we had 120 patients *not* using the pessary successfully, including those cases in which pregnancy resulted, and 35 who were *not* using the sheath successfully, including those cases in which pregnancy resulted. A considerable number of failures have turned to some other method, which means, of course, that the pessary, having the greater number of failures, has the heavier turnover.

In order to indicate this tendency it will be useful, perhaps, to tabulate the less than six months' experience of patients, because this category will include not only those who have been instructed in some method within the last six months before the investigation closed, but it will include all those who failed with one method and have turned to another, which, in most cases, they have used with success for several months—but less than six months.

Used method successfully less than six months:

Dutch pessary . .	10
Dutch + sol. . .	1
Sheath . . .	37
Sheath + sol. . .	1
Sheath or sol. . .	1
Semori . . .	1

It will be seen here that 37 are using the sheath. A large number of these are cases of pessary failures.

Some of the cases which failed with the pessary have since used the sheath long enough to be included in columns 1 or 2 of the previous table. Three patients, over varying periods, used both the sheath and the Dutch pessary, while 9 use either one or the other, the husband and wife taking in turn the responsibility for the contraceptive. In several cases the sheath is used in the winter and the pessary in the summer; in some cases the pessary is used during the spell considered to be the "safe period" and the sheath at other times during the month when pregnancy is deemed more likely to occur. This is the method followed by one young couple who had used the sheath with success for some time before the wife came to the Clinic, but she had felt depressed and had associated this depression with the sheath because it deprived her of a satisfactory culmination. These symptoms of depression have disappeared since they have used the pessary during the greater part of the time. One case has been successful with the Dutch pessary, but depends chiefly on douching before and after the act. One was successful for just more than a year with the contraceptive ointment used alone; she followed this method after she had broken her pessary, but has now gone back to the Dutch pessary used in conjunction with soluble pessaries on the advice of the Clinic.

One patient who has used the Prorace pessary of Dr. Stopes is included here, though it was not the method advised at our Clinic. She had used the Prorace previously, but came to the Clinic after it was opened, evidently in

search of something better. She was fitted with a Dutch pessary, but found it painful and returned to the Prorace pessary, which she has used with success ever since. During two periods she ceased to use it in order to become pregnant, pregnancy resulting in both cases. One of the pregnancies terminated in a miscarriage owing to an accident in which the patient was involved.

In a number of cases, though the patient is continuing to use the appliance with success, she finds some difficulty in connection with it, but continues in spite of this, because the disadvantage seems less objectionable to her than the danger of an unwanted pregnancy. One of those using the pessary (her husband also uses the sheath) finds that douching causes a feeling of great weakness in the legs. The same difficulty has been met by another patient, but in her case the pain was so intense that she was obliged to give up the pessary, and she now depends upon the sheath. One finds that the contraceptive jelly sometimes causes irritation. Another in column 6 of the table (p. 79), has used the sheath with success, but her case is suggestive of one-child sterility, since during fourteen years of married life she has borne only one child though she had never used any contraceptive previously. Another who has used the pessary for more than three years complained that she suffered pain during *coitus*. Recently, however, she has been operated upon for appendicitis, and since the operation the pain has ceased. The pessary evidently had not been the cause. One of those listed in column 6 has continued to use the pessary though her husband appeared some time ago to have become impotent. He has recently been removed to a

sanatorium as a hopeless case of tuberculosis. It is evident that even among the apparently successful cases it is necessary to admit the presence of other factors which have possibly had more to do with freedom from pregnancy than the appliance itself.

A number of our early cases show a history similar to each other. The wife took a sheath for her husband, who failed to use it, pregnancy resulting. Then the wife tried a pessary. Perhaps it failed also, or she could not continue to use it. In some cases a second pregnancy occurred. In every case the husband eventually agreed to use the sheath, but only when he found himself threatened with an avalanche of children. In some cases it was the wife herself who took matters in hand and delivered an ultimatum.

Several successful cases have complained of incontinence of urine while the pessary remains in place. One who wrote that she had used the pessary with success for a considerable period added, "but it isn't quite right yet". She referred to a feeling of slight discomfort which even old pessary users sometimes complain of. Several who persisted with the use of the pessary for more than a year have eventually given it up because they could never acquire any confidence in its use. One or two of those listed among the short-period sheath cases originally tried the pessary, but gave it up because their husbands objected. The husband apparently preferred to use a sheath rather than allow the wife to use the pessary.

We cannot pretend that this record of successful cases is as full as we should like, or that the experience of all

the patients in this class is as satisfactory as we could wish. The drawbacks and difficulties encountered even by successful patients is but another argument for the pressing need of better methods. But the Clinic has brought help and hope to so many patients, despite all the difficulties, that even the least enthusiastic supporter must admit the great value of the work that it has done. A few of the actual cases may be quoted.

Case No. 1.—Age 38 years. Nine pregnancies resulting in 9 living children, who were born in 1909, 1910, 1911, 1913, 1917, 1919, 1921, 1924, and 1927. Eight survive, one having died at four months. The entire family live in a tiny four-room cottage, and the wife has £2 a week for their support. The husband has always practised *coitus interruptus*. The patient originally had a pessary, but she could not manage it. The last child was conceived while the husband was relying on a sheath from the chemist's shop. For a year he has been using the sheath provided at the Clinic with perfect success.

Case No. 33.—Age 33. Eight pregnancies resulting in 8 living children, born in 1913, 1914, 1916, 1919, 1920, 1923, 1925, and 1927. One is deaf and dumb. The husband is a labourer, and the wife has a constant struggle to make ends meet; she is intelligent and tries to maintain a decent standard of life for her family. They live in four small rooms. The wife used a pessary, but she found it impossible to douche, and the last child was conceived while the pessary was being used without the douching. The husband is now using the sheath with success.

Case No. 36.—Age 42. Ten pregnancies, including 2 miscarriages; 7 living children. The husband is a labourer,

and the family live in four small rooms. The husband has used a sheath with success ever since the wife visited the Clinic three years ago. They had previously relied on *coitus interruptus*.

Case No. 51.—Age 29. She gave birth to a child in 1919, 1920, 1922, 1924, and 1926. She has 38s. a week to provide for them all. The husband practised *coitus interruptus* after the birth of the fourth child. He has used the sheath with success since the wife visited the Clinic more than two years ago.

Case No. 54.—Age 28. Eight pregnancies occurring in 1919, 1921, 1922, 1923, 1925, 1926, 1927, and 1928. Six children survive; both the last two pregnancies, which occurred after the patient had visited the Clinic, were completely wasted, for one resulted in a miscarriage and the other in a sickly babe who died at eight weeks. The husband began the practice of *coitus interruptus* after the birth of the second child. He also bought a sheath from the chemist, but couldn't "get on with it". The wife was pregnant for the fifth time when she visited the Centre. After the birth of her baby she came back and was fitted with a pessary. She tried to use it, but was always worried and nervous. She was never certain she had placed it properly when she tried to use it at home, although she appeared to place it satisfactorily when she visited the Clinic. She had no confidence in it, and eventually she became pregnant for the sixth and then the seventh time. Once more she came back to the Clinic for help. The husband again tried a sheath, and again found it very difficult to use. We then supplied a thinner one, which has been more satisfactory, and they are hoping, in spite

of all their previous difficulties, to be able to avoid any further pregnancy from now on.

Case No. 58.—Age 27. Children born in 1924, 1926, and 1928. The husband has tuberculosis. The wife was pregnant on her first visit to the Clinic, and after this (second) baby was born she was supplied with a sheath for her husband. He disliked it, and neglected to use it, whereupon the third pregnancy ensued. Another kind of sheath has since been supplied, which he is using with success.

Case No. 228.—Age 35. Seven pregnancies occurring in 1914, 1915, 1917, 1919, 1922, 1924, and 1926. Five children survive. The husband is a labourer. The wife was fitted with a pessary, but had no confidence in it, and eventually gave it up. The husband has been using a sheath with success for more than a year. Our patient is extremely grateful for the help she has received. She says that the last two years have been the happiest in her life. She has recently moved out of a tiny four-room cottage into a new Council house with a bathroom and a garden. Her husband, who for years had nightly fled to the public-house from the discomfort of his overcrowded house with its crying children and work-worn mother, has now given up drinking and takes an interest in his new house and garden. They both place complete reliance in the sheath, and have confidently put behind them the constant worry about unwanted children, which previously harassed them. At 37 our patient is beginning to enjoy life, to find happiness in her children; and she faces with calm assurance the inevitable difficulties which beset the home of a labourer with his scanty wage, now that her most

constant worry has been removed—the fear of another pregnancy.

Case No. 69.—The following letter was received from this patient a few months after the Clinic was opened:

No doubt you will be surprised to hear from me but - I thought I would write and let you know I got my new baby what I told you about when I first fell, born on 23rd December so I have a Xmas in bed, not very nice for my husband and children I do wish you had opened your clinic before as I did not want any more I hear that you are getting on alright with it, you see I had just fell in the net so it was no use me coming up there fancy that makes me 7 alive and 2 dead, and what is a man's money when you get it, I always went to work mornings until I could not go any longer I went until 3 months ago and then had to give up as I did not feel the woman with the ninth as I did with the first and had to do it as I only have one earning besides my husband, I am afraid I shall be booked now to stop at home as my other little girl is 2 so it would not pay me to go out to work with 2 to pay for, I have been thinking I should get my maternity money as well as my husband, and now I don't think I shall as my baby is born this year, instead of next as I am not in Benefits till January and had I went my time I should have been confined between the 5th and 10th January so it is about a fortnight before, never mind I shall have to come up the clinic when able to get there as just fancy I am only 38 and had 9 children.

This patient has used the pessary with complete success ever since the birth of this ninth baby. The infant died a few days after its birth. The mother was "glad when it died". She has often taken drugs to try to bring about a miscarriage. Once she was blind and deaf for three days as the result of taking too much quinine. She has 6 living children, and is sure she would have at least one or two

more by this time if the Clinic had not provided her with a means of escape.

Case No. 99.—Twelve pregnancies resulting in 11 living children (1 pair of twins) and 2 miscarriages. She often took gin and Beecham's Pills to bring about a miscarriage, and thinks that some of her children were born frail and weakly for this reason. The husband is a factory hand, and the family live in three rooms. We supplied the wife with a sheath for the use of her husband, as it was obvious that she would not be able to manage the pessary and douching. But the husband failed to use the sheath on a few occasions, preferring to rely on *coitus interruptus*, which he had practised throughout their married life since the birth of the first child. The twelfth pregnancy resulted, but the wife returned to the Clinic of her own accord afterward and promised that the sheath would be used faithfully in future. She has since returned several times for fresh supplies. It looks as though the husband had at last been convinced that *coitus interruptus* is not a reliable protection against pregnancy.

Case No. 300.—Age 42. Eleven pregnancies—2 miscarriages and 7 living children—occurring in 1904, 1906, 1908, 1911, 1914, 1916, 1918, 1919, 1922, 1923, and 1927. The patient is a frail little woman. In every case she went through two days of labour, and delivery was eventually effected with the aid of chloroform and instruments. She had never used any method of contraception previously, but has been completely successful with the pessary since she registered at the Clinic on May 24, 1927.

No case could give greater satisfaction than the last. Yet we are often convinced that it is even more important

to reach the young mother whose family is still of manageable proportions. We would like to provide every young mother with a safe and easy contraceptive, which would insure her against the inhuman suffering through which this last patient has passed during the twenty-two years of her married life.

CHAPTER VIII

PATIENTS' PREVIOUS METHODS

IN general, the methods used by patients before coming to the Clinic show the same disadvantages and difficulties that we have already noted as applying to the Dutch pessary and the sheath. Those who had tried any method at all before visiting the Clinic had usually tried several at different times. Many of them took no precautions until they already had had several children.

The general lack of satisfaction with existing methods is demonstrated again by the experience of these patients who tried first one thing and then another, finding them all unsatisfactory or unreliable, and coming at last to the Clinic in the hope of discovering something which could be used with ease and certainty.

The most interesting feature of this review of previous methods is the wide extent to which *coitus interruptus* has been practised, and the very large number of failures resulting. I am able to report on the previous method used by 265 patients. Out of this number 118 had practised *coitus interruptus* during all or part of their married life. The number of pregnancies occurring among this 118 *while* the couple were relying on this method was 409. Five of these pregnancies produced twins. This does not take into account the children conceived when the couple were taking no precautions or when they were using some other method. The 409 pregnancies are direct failures of the method of *coitus interruptus*.

Thirteen patients employed this method during some

part of their married life with success—that is, no pregnancy occurred while *coitus interruptus* was the method being used. Only 4 of these patients, however, continue to rely on this method at the present time, and one of these is now pregnant. Three use the Dutch pessary, 1 the Dumas, 4 the sheath, and 1 depends on either *coitus interruptus* or soluble pessaries.

Only 76 of the 265 patients had never tried any contraceptive before coming to the Clinic. This group show a total of 286 pregnancies, with 4 pairs of twins. A further group of 69 are known not to have practised any method of contraception during some part, but not all, of their married life. Some of these started with contraceptives after several children had been born, and persisted with one method or another continuously. Others tried one method and then another intermittently. This group has a total of 214 pregnancies occurring when no precautions were being taken against pregnancy, with two pairs of twins.

Eighty-six patients tried various methods and combinations of methods other than *coitus interruptus* over various periods of time, during which no pregnancy occurred in 64 cases, and 22 others relied on some method which failed, 32 pregnancies resulting.

It is much easier to classify and discuss the failures than the other 64 cases. There is nothing indefinite or uncertain, for instance, about the case of a woman who was employing a pessary and pregnancy resulted in spite of it. But there is a good deal of uncertainty attached to methods which were used over an indefinite period and in an undefined sequence, where no pregnancy resulted.

The experience of the non-failures is too limited, and usually of too short a duration, to justify their classification as successes. In the table, therefore, in which I have attempted to give the details of the pre-Clinic methods, I have used the terms "failures", "no evidence of failure", or "non-failures". The failures are the cases in which pregnancy occurred, despite the method employed. The cases which did not become pregnant are put under the non-failures classification. To provide some indication as to how far these non-failures might honestly be classified as successes, I have added two columns to the table, taken from post-Clinic experience. One of these columns indicates the number who are still persisting with the methods they employed before visiting the Clinic, and the last column shows what methods are being used at the present time if there has been any change. It would probably be a fair generalization to say that those from the non-failures class who are still continuing with the same method can be counted as successful cases.

It is practically impossible to obtain accurate details about contraceptive methods used over a period of several years. Even the most intelligent patient forgets when and how long any method was employed, unless there is a definite case of pregnancy to impress it on her mind. It is impossible to state that any method was used over a very definite period; but such recollections about previous methods as could be elicited are both interesting and illuminating, and are summarized in the table on page 97.

In some cases, though a contraceptive device was pur-

chased, it was never used, because the patient did not know how to adjust it. This is especially true of the cervical, Prorace type of pessary. Nineteen patients tried this pessary before coming to the Clinic. Pregnancy resulted in 7 cases, and 7 others could not use the pessary at all. One used it once or twice and found it too painful to continue; 2 used it successfully for nine months or more. One, who continues to use it at the present time, in preference to the Dutch pessary, has been successful for approximately five years. The other 18 are now using other methods successfully, as follows: sheath, 8; Dutch pessary, 6; sheath or Dutch pessary, 2; sheath and Dutch pessary, 1; sheath and soluble pessaries, 1.

Those who tried the sheath were more successful. In some cases those who failed, or who gave it up because they found it too thick and heavy, or too expensive, have since been successful with a more suitable sheath, such as is supplied at the Clinic. Thirty-one couples had tried the sheath, with three resulting failures. Twenty of these patients are using the sheath at the present time: 2 use it in conjunction with the soluble pessaries because of nervousness resulting from a previous failure, and 3 as an alternative to the Dutch pessary. Of the remaining 11, 5 use the Dutch pessary, 1 soluble pessaries, 3 depend on *coitus interruptus*, and 2 take no precautions.

More than half of those who depended on soluble pessaries failed—8 out of 15. Two were successful, 1 over a period of four years; but she also douched immediately after *coitus*, so that credit must be divided between the two methods. Only one of this group depends on the soluble pessaries at the present time. The others are

divided as follows: Six use the sheath (2 in conjunction with solubles), 2 the Dutch pessary, 1 either the Dutch or the sheath, 1 Semori, 2 abstain completely, and 2 take no precautions.

The medicated sponge failed in one case out of four. These patients are now relying: 1 on the Dutch, 1 on the sheath, and 2 on the sheath plus solubles. One patient succeeded for a period of two years with a cotton plug soaked in glycerine. But she was seriously ill during much of this period, and she thinks it unlikely that she would have become pregnant in any case.

Four depended at intervals on douching. No failures resulted, and one of these patients still places more reliance on this method than on any other. One used a Dumas pessary with success and still continues with this method, while another tried the Dumas and couldn't use it at all. One tried the Dutch pessary and failed, but has used it with success since she was fitted at the Clinic.

Two depended on salts, pills, and other drugs to prevent or immediately terminate any pregnancy. One of these, after each connection, took pills of the sort commonly advertised as capable of curing "all female irregularities", and believes that her freedom from pregnancy can be traced to this cause. The other relied on quinine, salts, or some aperient taken before the period each month. It is difficult to classify these cases, but as the last named had five pregnancies it may be assumed that her methods were not successful.

Many other patients have from time to time taken drugs in an effort to bring on a delayed period. But only

these two had regularly employed this method to guard against unwanted pregnancy. Similarly, many more than the six patients listed in the table had abstained from intercourse for weeks or even months at a time because of illness or absence or following the birth of a child. But only these six had deliberately chosen this method to prevent conception.

One case is listed as relying on suckling the last child over a long period as a means of preventing unwanted pregnancy. As a matter of fact, many patients—a majority I should think—breast-feed their children as long as possible for reasons of convenience and economy. Many of them believe that they will not become pregnant while suckling their baby, and this may influence them to prolong the lactation period as far as possible. I found a number of patients who were not taking precautions during the lactation period, but most of them did so when warned against this method as a reliable contraceptive. But I found only one patient who said she had definitely tried to limit her family through this method. Her success was not very conspicuous—she had given birth to seven children.

The whole of this evidence is summed up on pages 96 and 97. It must be borne in mind that the table contains the experience of 265 patients, many of whom had experience with several methods, and each of whom will be listed in the appropriate columns dealing with that particular method. Statistical sticklers are warned against attempting to add up the columns to any significant totals—it can't be done.

RESULTS OF CONTRACEPTIVE METHODS USED PREVIOUS TO VISIT TO CLINIC

I. Pregnancies when no method used by (76) couples never using any method (4 pairs of twins)	286
II. Pregnancies when no method used by (69) couples sometimes using some method (2 pairs of twins)	214
III. Pregnancies when *coitus interruptus* used (by 118 couples) (5 pairs of twins)	409
IV. Pregnancies when method used other than *coitus interruptus* (by 86 couples) (no twins)	32
TOTAL PREGNANCIES (among 265 couples)	941

There is considerable variation between this former experience of our patients and that of the patients who attended the Mothers' Clinic of Dr. Stopes, and who consulted Mr. Haire on contraceptives, as will be seen by comparing the tables quoted from these two authorities on page 45 and the table opposite. The most impressive difference is in respect to the sheath, where we found three failures out of thirty-one, while Dr. Stopes records 75 per cent. failures and Mr. Haire 51 per cent. With the method of *coitus interruptus* we record 105 failures out of 118 cases, while Dr. Stopes's percentage is 81 and Mr. Haire's 69—all three tables showing substantial agreement in this respect.

Too much importance, however, must not be attached to any of these figures. It is too difficult to get reliable information as to past experience when one must depend

DETAILS OF CASES OF COUPLES USING *COITUS INTERRUPTUS* OR OTHER METHOD

Method.	Number Trying.	Failures (one or more pregnancies)	No Evidence of Failure.	Now Using Same Method.	Now Using Other Methods.
Coitus Interruptus	118	105	13	42	76 (various other methods)
Sheath	31	3	28	20 { 2 + Sol. 3 or D.	5 Dutch, 1 Sol. 3 *C.I.*, 2 nothing
Cerv. Cap	19	7 (1 + Sol.)	12[1]	1	8 S., 6 D., 1 S. + Sol. 2 Sol., or D., 1 S. + D.
Sol.	15	8	7	1	6 S. (2 + Sol.), 2 D., 1 D. or S. 2 Abst., 2 nothing, 1 Semori
Med. Spg.	4	1	3	0	2 S + Sol., 1 D., 1 S.
Douche	4	0	4	1	1 D., 1 nothing, 1 Dumas
C.p. and Gly.	1	0	1	0	1 Dutch
Abstinence	6	0	6	2	2 Dutch, 2 Sheath
Dumas	2	0	2	1	1 Dutch
Dutch	1	1	0	1	—
Drugs	2	1	1	0	1 Dutch, 1 Sheath
Suckling	1	1	0	0	1 Dutch
All methods other than *C.I.*	86	22	64	27	

Explanation of Abbreviations

C.I. for *Coitus Interruptus*.
D. for Dutch pessary.
Cerv. Cap for cervical Prorace type pessary.
C.p. and gly. for cotton plug and glycerine.
Sol. for soluble pessaries.
Med. Spg. for medicated sponge.
Drugs to include quinine, salts, gin, etc.
Abst. for abstinence.
S. for Sheath.

[1] 7 out of the 12 tried but could not use.

entirely on the recollection of the patient and on her willingness to go into her past history. I found a greater reluctance among many women to talk about previous methods, partly because they could not remember, and partly, I think, because I had less business to be prying into that part of their lives. It was always easier to discuss the methods they had started to use upon coming to the Clinic, and a reliable history of those methods was much easier to achieve, inasmuch as we had made and kept all the original records ourselves at the Clinic, providing accurate reference to dates, etc. I am inclined to believe that definite reliance should be placed only on data gathered after the patient has visited clinic or doctor. It is possible then to trace the patient's subsequent history with a sufficient accuracy to satisfy those who rightly demand scientific precision before conclusive judgments can be reached in the matter of contraceptives.

CHAPTER IX

COMPARISON OF RESULTS

Now that the experience of patients, both before and since their visit to the Clinic, has been analysed and tabulated, it is possible to make at least a tentative assessment of the merits and difficulties of each of the methods under discussion.

There can be little doubt that *coitus interruptus* is the method which has been, and is still, the most widely used. It is technically described amongst the workers as "being careful". It was the method advocated by the birth-control pamphleteers of the early nineteenth century, and there is evidence that it has a still more venerable history. Onan was slain because in his determination not to raise up seed to his brother's widow he used this method. And it is probable that through the centuries since this incident was recorded in the Bible, this contraceptive has been employed to a far greater extent than anyone imagines. There is a generally accepted belief that the negligible survival rate in France can be accounted for by the universality of this practice among Frenchmen. But more stress is usually laid on the influence of contraceptive practice in France than it really deserves, while small account is taken of the amazingly high infant mortality rate, which is the more important factor in the low survival rate in that country.

Missionaries working amongst primitive tribes, and anthropologists searching out a record of the lives of these tribes, have given us much food for thought in the

matter of contraceptives. We are told that amongst certain tribes intercourse is obligatory at certain times, such as at a stated interval after the birth of a child, but it must occur without pregnancy resulting. In other tribes husbands and wives *may* resume relations after a prescribed interval following the birth of a child, but again there is a taboo against pregnancy resulting. These taboos are successfully obeyed. But how?

Coitus interruptus is the one method in common knowledge which does not require either preparation or mechanical appliance or chemicals or drugs. It can be employed absolutely secretly without taking any third person into confidence, as is necessary if any contraceptive is to be purchased. It has not the drawback of mechanical appliances which are found to be torn or worn out or mislaid when needed, or of soluble pessaries or chemicals which so frequently run out before a fresh supply is secured. It has the advantage of appearing theoretically to be perfectly certain in its results. And it is so simple that it might well occur even to primitive minds.

The amazing thing about *coitus interruptus* is the reliance which couples continue to place in it even after they have had a number of failures. We have had cases who have practised *coitus interruptus* throughout their married lives, as many as twelve children resulting. And we have a considerable number of cases with four or five children born despite the practice of this method. Husbands reason that if no semen is deposited in the vagina, no conception can take place; and it seems to require much more than several accidental pregnancies to convince them that their assumption that no semen *is*

deposited may not be warranted. One of our patients suggested that failures might often occur in cases where the husband made a practice of re-entering after ejaculation took place in order to bring about a proper culmination in the wife.[1]

On the whole, husbands place greater reliance in this method than the wives. Over and over again patients have said to me, "The more careful you are, the more you seem to fall." One of our patients had borne five children, though her husband had practised *coitus interruptus* since the second. She was fitted with a pessary, but the husband still insisted that his method was the more reliable. Our patient very much disapproved of the method because it deprived her of all pleasure and left her continuously nervous and high-strung. She refused, however, to use the pessary unless the husband would discontinue withdrawal. The result was that a sixth pregnancy occurred. Now the husband agrees to try the pessary instead.

And it doesn't matter how often an accidental pregnancy has resulted from this method—the husband is always just as surprised and just as indignant as though it had happened for the first time. Many times a patient suspecting pregnancy has said, "My husband says I can't be like that, but I know I am", and more often than not she is right. We have had a few pathetic cases of tearful women whose husbands had accused them of unfaithfulness because pregnancy had occurred when the husband practised *coitus interruptus*. Many husbands do not realize that impregnation often occurs through a slight

[1] See also *Geburten Regelung*, p. 31. Edited by Dr. Kurt Bendix, Berlin, 1928.

premature ejaculation of which they are completely unconscious; and they are not aware that the millions of spermatozoa to be found in each ejaculation of semen are mobile, and capable of finding their way to join a female seed, even though deposited only at the mouth of the vagina. Ignorance of these simple physiological facts causes endless misery and unhappiness.

Many of our patients suffer no ill-effects, apparently, from *coitus interruptus*. Often the only thing of any importance to the wife is that *coitus* should be got through as rapidly as possible, so as to rid her of the fear that pregnancy is going to result. The fear of pregnancy—that is the only emotion many women feel, and they do not mind what happens if only that fear can be allayed! And some husbands do not seem to mind withdrawal—they prefer this method, with its freedom from preparation, to the other methods which are available to them. Forty-two of our patients, it will be remembered, have gone back to *coitus interruptus* after investigating other methods offered at the Clinic. Most of these do not consider that any harmful results can be noted.

But a considerable number of patients have complained of nervousness and irritability on the part of either the husband or wife, or in some cases both. I remember one patient who came to us in tears because her marriage had become so unhappy. She was seriously asking herself whether she could continue to live with her husband, who seemed to be in a permanent bad temper. They were living in rooms, and wisely wanted to postpone the birth of their first child until they could get a house. The husband always practised *coitus interruptus*. We supplied

the wife with a pessary. Six months later she came back beaming with joy. Her appearance was so changed that all the workers at the Clinic who had seen her on her first visit remarked upon it. She said that her husband's irritability had almost entirely disappeared since he had ceased to practise *coitus interruptus*, and that their married life became happier every week. After a time this couple moved into a house, the wife gave up the pessary, and they now have a daughter.

There can be no doubt whatever that a very large number of patients who practise *coitus interruptus* feel very great anxiety, which results in nervous tension and strain. The husband is under the necessity of being on the alert to withdraw at the crucial moment, and the wife suffers great anxiety lest he shall fail to do so. The worry must be added to the other strain, physiological and psychological, which the sudden interruption of an emotional crisis entails. Many women have told me that, even though they were extremely fond of their husbands, they felt intense resentment, amounting almost to hatred, when this interruption deprived them of a proper climax. And this hostility and dissatisfaction was likely to last through the next day, making work difficult, and dealings with the children curt and ill-tempered. As one intelligent patient expressed it: "If it's been successful for me I feel a great wave of love for my husband. I get up the next day happy and contented and work is easy. If it hasn't been right, I feel as if I'd like to murder him, and everything goes wrong the next day." The fear of failure holds true also in the case of other contraceptives in which the couple have not complete confidence.

Many wives have told me how the dread of pregnancy haunts their lives like a nightmare,[1] how they dare not show any affection for their husbands for fear it will lead to sex indulgence; how, when they can no longer "put off" their husbands, they think of nothing except a possible "accident"; the endearments of wife to husband take the form of: "Do hurry up!" "Do be careful!" "Don't be so long!" "I'm sure you're not going to be in time!" The whole act, which ought to be a happy expression of their love for each other, becomes a strained and miserable business, more often than not resulting in quarrels, ill-temper, and worry.

Opponents of birth control make much of this nervous strain felt by many who fear that their contraceptive will fail. But do they argue that a contraceptive—particularly one more certain than *coitus interruptus*—which offers at least some security against pregnancy, is less reassuring than no contraceptive at all? If those who have taken some precautions against pregnancy feel nervous anxiety, what must be the state of their minds if no precaution at all is taken?

It is no remedy for nervous strain to suggest a serene indifference to contraceptive measures and a reckless irresponsibility toward the possible consequences. The remedy lies in a sound contraceptive device on which couples can rely with faith and assurance.

There seems much confusion on this matter of *coitus interruptus*. Most patients do not consider it as a contraceptive method at all, and, as mentioned already, we

[1] See *Geburten Regelung*, pp. 75–78. H. Pinéas, "Psychischnervöse Auswirkungen der Konzeptionsangst."

always make special reference to it when asking them about their previous experiences with birth control. On the other hand, some doctors and others inadequately informed on contraceptive practice seem to consider that it is the only method available. I was surprised, when arguing the question of harmful results with a doctor not long ago, to find that he had referred throughout our conversation to this one method only, and that, moreover, he thought we had opened the Clinic in order to give people instruction in this method! He had argued that birth control caused nervous disorders, I had argued that birth control relieved nervous disorders. He meant *coitus interruptus*, and I referred to the methods advocated at the Clinic. He was very much surprised indeed when I told him that we were in complete agreement, for the Clinic always discouraged *coitus interruptus*, believing it to be not only often harmful, but most often useless.

Whatever may be said against *coitus interruptus*—and there seems a very convincing case to be made out against it—one must admit that it has been, and is still being, practised very widely; that it has tended to the spacing of children over wider intervals even though it has not always succeeded completely in preventing pregnancy; and that it has undoubtedly had a very important influence on the declining birth-rate.

It is very difficult to produce evidence on which to base a judgment in the matter of relative popularity of other contraceptive methods. But I should say that the sheath, or French letter, or condom, as it is variously called, probably comes first. It is interesting to note that both the sheath and *coitus interruptus* are measures put into

practice by the husband. Though the medicated sponge or cotton plug to be used by the wife were recommended in some of the earliest birth-control pamphlets, and though pessaries in a wide variety of shapes and sizes have been put on the market, and widely advocated by the birth-control clinics, yet they do not seem to be so generally used or, if the experience of our Clinic can be considered as any guide, so successful.

The experience of our patients in respect to the sheath seems to contradict the views held by many other advocates of birth control. We have not found, as did Dr. Marie Stopes, that "almost without exception every woman whose husband has ever used it detests it wholeheartedly, and that *in* 75 *per cent.* of those cases who used it before coming to the Clinic *it has failed*".[1] We found three failures out of thirty-one cases in our pre-Clinic experience. And records from our own Clinic show that 120 cases who started to use the Dutch pessary failed or gave it up, while 35 cases who tried to use the sheath gave it up or failed.

A few women have said definitely that they liked *coitus* better with the sheath than without; that they would prefer having the sheath used even though they knew that they would not become pregnant in any case. This preference was based on reasons of cleanliness—they disliked the presence and the odour of semen—and on the fact that the use of the sheath tended to retard the climax in the husband, allowing time for the wife to reach a proper climax herself.

Except for these three or four women I have not found

[1] *The First Five Thousand*, p. 43.

any woman who would say that she *liked* the sheath. Nor have I found anyone who confessed that she *liked* any method of control. Almost every wife—and most husbands too, would prefer *coitus* unhindered by conscious control or mechanical devices. No birth-control advocate denies the contention of some psychologists that all devices are disliked by their users. But we do challenge the conclusion, often drawn, that the use of a contraceptive contrivance therefore causes grave annoyance and neuroses.

One central fact seems always to be overlooked. It is this. The one thing in the world which a woman fears and dreads more than anything else, the one thing that fills her with sick terror, that hangs over her days like a heavy cloud, that fills her nights with loathing and repugnance—that one thing is fear of an undesired pregnancy. It is sheer nonsense to say that because women dislike contraceptives, or because they are nervous lest a failure shall result, they should therefore abandon all precautions, and presumably acquire at once complete peace of mind. Contraceptives are not pleasant or desirable in themselves; but when they offer a release from a much more serious consequence, they are not only tolerated, but welcomed. And they are of tremendous importance to women. Sir Arthur Newsholme,[1] who talks about "such a minor factor in life as contraceptives", obviously has little idea of the woman's point of view. Mrs. Clay[2] says: "I do not think I have ever met a woman who *wanted* to use contraceptives. Women use them, but they have told

[1] *Medical Aspects of Contraception*, p. 132.
[2] *Ethics of Birth Control*, p. 90.

me that they have only used them because their husbands have wished them to. In some instances women have gone so far as to say: 'I am so sick of the whole business that I almost would rather my husband had a mistress to go to than that I should be obliged to go on using these things; if I could be natural and have children when they came I would not mind.' "

This is so diametrically contrary to all our Clinic experience that I cannot help wondering whether the printer should not have made the sentence read: "in *one* instance a woman has gone so far", etc. Mrs. Clay would meet hundreds of women eagerly seeking contraceptive knowledge if she visited any Birth Control Clinic.

The women have given me many reasons for preferring the sheath to the pessary. The first is that it seems safer to them. One can ascertain, with a fair amount of certainty after the act, whether there is any likelihood that an accident has occurred, and one can then put one's mind at rest. The one thing of paramount importance is confident assurance that "nothing has happened". And the sheath offers this more readily than any other method. The sheath eliminates the uncertainty of wondering whether preparations need be made—it is in the control of the husband, and, as has already been pointed out, most women regard initiative in sex matters as something exclusively the province of the husband. It does not require any preparation on the part of a tired woman at the end of a busy day, nor any task of douching at the beginning of another busy day.

The disadvantages which some of our patients have found in the use of the sheath are similar to those which

have been pointed out by most writers on the subject of birth control. Some of our patients did not dare to trust their husbands, who, especially on a Saturday night, if they were not quite sober, or if they happened to be in a sulky mood, might not take a serious view of their responsibilities. I recall one interesting case. Under ordinary circumstances the husband was good-tempered and quite willing to use the sheath. But he held to a profound degree the old notion that "woman's place is in the home". His wife was an alert and intelligent woman who liked to go to meetings and take part in the affairs of her parish. When he found she had been an afternoon away from home, he would sometimes be very angry. At such times he held the threat of pregnancy over his wife. "I'll give you something to stay at home for", he would tell her, and she knew that he meant not to use the sheath. At first this frightened her, and fear often restrained her from taking part in activities outside her home. Then she resolved to deal with the matter herself. She came to the Clinic and was fitted with a pessary unknown to her husband. "Now," she says, "when he threatens me, I just smile."

In a few cases the sheath, by preventing the contact aimed at in the sexual act, definitely interferes with the wife's pleasure, in a few cases it decreases the pleasure of the husband. A few of these have turned to the pessary as a contraceptive, but for the most part the couples—especially the wives—consider "safety" of far greater importance than anything else, and stick to the sheath in spite of its disadvantage. We have had some cases in which the husband, though making an intelligent effort to do

so, could not use the sheath; it caused premature ejaculation, or it interfered so seriously as to prevent erection. Some of our patients have found the sheath objectionable on aesthetic grounds; it is too obvious a method, it necessitates an interruption at a moment when conscious control is least desirable, the odour of the rubber intrudes itself upon their consciousness and emphasizes their awareness that a contraceptive is being employed. In some cases the husband found the sheath much too thick and heavy; in a few cases it caused pain, especially to the wife.

Some of these difficulties we were able to overcome. In one case in which the wife complained of pain our doctor prescribed douching with lactic acid to overcome the tenderness and the sensitive condition of the membranes. For the one who disliked the smell of rubber we provided a slightly scented ointment to act as lubricator. We have examined many kinds of sheaths varying in thickness and texture in order to find those most satisfactory. The one most commonly in use at the Clinic was brought to our attention originally by one of our patients who had been unable to use the pessary, and after a resulting pregnancy had sent away for sheaths which a work-mate of her husband recommended. We have always made a practice of sending at once for any appliance any patient has found satisfactory, and of adding it to our stock. Many of the patients who found our original sheaths too heavy, or who had objected to very heavy sheaths bought elsewhere, are now using the thinnest kind with full satisfaction.

The sheath suffers also from the disadvantage that it cannot—or should not—be used over a long period, and

it is not always replaced in advance to be ready when needed. But it is *not* expensive as so many have declared. It is the cheapest contraceptive known.

We do not deny that the sheath has many disadvantages. It is far from the ideal contraceptive—which has yet to be discovered. But the experience of our patients has led us more and more to the view that it is the best and safest contraceptive available, in all cases where the husband can and will use it faithfully.

The Dutch pessary is the type with which most of our patients have been equipped when a pessary seemed desirable rather than the sheath. A few of our patients, as the table shows, use both methods simultaneously. In a few instances the Dumas pessary seemed more suitable. We have also the Prorace pessary, but we have had no case in which this pessary seemed more applicable than the Dutch. It has been frequently tried at the Clinic, and in most cases not only the patient but the doctor found difficulty in adjusting it. One patient who had previously used the Prorace pessary complained that it was very difficult to remove and had caused inflammation of the tissues. Mention has already been made of one patient who returned to the Prorace pessary after a trial of the Dutch, and continues to use it successfully. Several other patients came to the Clinic with pessaries of a similar type which they had been using with success. In these cases, when the doctor ascertained that the pessary seemed to fit well, and that the patient understood its use, she recommended its continuance. We always offer to supply any type of pessary which any patient has previously found satisfactory.

The most serious disadvantage in the Dutch pessary—and this applies also to any type of pessary—is the uncertainty in its use. Over and over again women have told me, when I asked why they gave up the pessary, that they "couldn't get on with it"; they "had no faith in it"; they could never be certain whether it was properly placed. Intelligent women, who know something about physiology, have told me many times that though they tried over and over again they never felt absolutely certain that the pessary was in place; that though they knew where the cervix should be found, and what it was like, they could never convince themselves that they could feel the cervix through the pessary, as they should. It is small wonder that an ignorant woman who knows nothing of physiology, and who regards her own interior as an awe-inspiring mystery, should experience grave misgiving when asked to place a pessary in the vagina, and should never feel any confidence in her ability to place it properly. Some of our patients tried using the pessary six months or a year, and even then gave it up because they had never acquired a feeling of certainty about placing it. A few of those who could not acquire confidence in the use of the pessary pointed out that the pessary in the morning appeared to have shifted its position considerably; it often seemed to be tilted or to lie horizontally rather than transversely in the vaginal passage. When they followed instructions to douche first and then remove the pessary they found considerable water behind the pessary. What benefit, they asked, could be derived from douching the vaginal passage to free it from any spermatozoa that might still be alive if, in fact, the water

—and quite possibly the spermatozoa—were forced behind the pessary?

And even when confidence in placing it has been acquired there is always the uncertainty as to whether it is fulfilling its mission. There is no means of *knowing*, as is the case with the sheath, whether pregnancy is likely to have taken place, and there is a feeling of dread and anxiety which disturbs the patient from month to month.

The necessity of douching, the following morning, and the great difficulty this presents, has been mentioned in a previous chapter, but it deserves emphasis, because it eliminates the pessary as a practical contraceptive in the case of a great many women. The smaller the house, and the greater the number of children, the more pressing the need for an effective contraceptive, and, to close up the vicious circle, the less likelihood that the woman can find means for douching. There is no doubt whatever that the use of any contraceptive, and especially the pessary, with the attendant douching, becomes infinitely more difficult and less successful in tiny, overcrowded houses. A decent house for every married couple would go a long way toward facilitating the successful application of any contraceptive.

Some of our patients have complained that they found the pessary painful, or that their husbands were aware of its presence. This has sometimes been improved by altering the size of the pessary. Another found it interfered seriously with the normal contractions of the muscles during *coitus*. Some complained of incontinence of urine while the pessary was in place, and a few, as already

mentioned, found that it caused "bearing-down" pains. One, previously cited, could not use it because it caused haemorrhoids. As soon as she ceased to use the pessary, the trouble disappeared.

In many cases it is, of course, practically impossible to fit a pessary of any kind. A majority of our patients have suffered injury from previous childbirth and lack of proper ante- and post-natal care. This condition is, in fact, so prevalent as to be a scandalous reflection on the casual and indifferent attitude that has hitherto been maintained—and is still maintained in many circles—toward this important subject of childbirth. Here again there is a vicious circle. For the more seriously damaged the woman, the greater the necessity to protect her from further injury likely to result from additional pregnancies, and the greater the difficulty in applying the contraceptive.

Seventy-eight of the patients under discussion were found on examination to have a lacerated cervix, and 56 a torn perineum—in many cases, of course, both conditions were shown in the same patient. Four of these had contracted pelvis, and nearly a dozen more showed inflamed condition of the membranes, or eroded cervix. Twenty-three had retroverted uterus, and 8 were suffering from severe prolapse of the uterus. It is probable that this record of damaged or abnormal patients would be even greater if every patient who came to the Clinic would submit to an examination.

Another serious drawback in connection with the pessary is the general prevalence of constipation. It is quite impossible to fit a pessary if constipation is acute,

and it is equally impossible to use one with any hope of success in such a condition, as it will not remain in place. We have already quoted the case of one failure due to this cause.

But whatever shortcomings the pessary has—and we have made no attempt to spare its feelings—it is quite free, so far as our experience goes, from one fault attributed to it by Dr. Stopes, who says: "The Dutch cap would be less objectionable than it actually is were rubber indestructible, but as we have found by repeated experience, some women's vaginal secretions destroy rubber; hence the raw-ended wire in the Dutch cap is liable to come through and lead to abrasions and the other dangers which Professor McIlroy and others spoke of in the Stopes-Sutherland case as if they applied to the 'Prorace' cap used at our Clinic, which they do *not*."[1] I have examined many old pessaries brought back to the Clinic for inspection, and a number of broken pessaries, and I have never seen the slightest evidence of a "raw-ended wire". I have broken a pessary purposely, and tried to force the wire through the rubber covering, but without success.

There is a slight amount of evidence to support another contention of Dr. Stopes concerning the Dutch pessary. She contends that it is likely to stretch the walls of the vaginal canal. It sometimes happens—though this has been rare—that a patient returning for re-examination after having used the pessary for some months is fitted with a slightly larger size than she had originally. The medical officer at our Clinic thinks it is possible that if

[1] *The First Five Thousand*, p. 39.

the pessary is used very frequently—every night or very nearly every night—and is left in place overnight as the patient is instructed, it may have a tendency to stretch the vault of the vagina. On the other hand, a number of patients, who have used the pessary since our Clinic was opened, continue to have the same size fitted on re-examination, and there appears to be no change in the shape or size of the vagina. If this suspicion that there is sometimes stretching of the vaginal vault can be confirmed, it will perhaps help to explain some of the pessary failures which have occurred after the patient has used the appliance with success over a period of several years, because a pessary of the original size would have become too small.

As was the case with most of those using the sheath, we have not found any woman who *likes* the pessary. A number who use it with success resent the trouble entailed and the lack of simpler method. But some of those who use it much prefer it to the sheath. They point out that it can be inserted in advance (though there is a difficulty in this connection when using a quinine tablet as has been previously mentioned), and that it is not so obvious a method as the sheath. Some of our patients like douching and the feeling of cleanliness and freshness that results, and some have felt definitely improved in health in consequence of douching. Others dislike douching and consider that it produces painful symptoms.

One of our patients leaves the Dutch pessary in place for several days at a time. If she feels that any secretions have accumulated, she tips up the pessary with her finger, and allows the secretion to escape. She takes the

pessary out occasionally, douches, and puts it in place again. She has found this method perfectly satisfactory.

We have never recommended the soluble pessaries to be used alone, as the experience of patients who tried this method before coming to the Clinic has indicated the great inefficiency of this method. One of those who failed with the soluble pessary used two each time! But a few of our patients rely on soluble pessaries during certain times in the month, though they use the sheath or Dutch pessary at other times, and a few use them as their only precaution. We have found the soluble pessary extremely useful as an adjunct to other methods in cases where the patient showed great nervousness and found it very difficult to acquire confidence in anything. In such a case we urge the employment of several methods simultaneously until the patient has gained confidence. A number of the patients who originally had not enough confidence in the sheath to use it, except with soluble pessaries, now place reliance on the sheath alone.

In a few cases the patient objected to the soluble pessaries because they caused too much lubrication. In another case a patient who had been accustomed to use soluble pessaries and then tried the Dutch pessary, went back to the soluble pessaries in conjunction with the Dutch, because she and her husband had become so accustomed to the additional lubrication.

A great disadvantage, apart from its unreliability as a contraceptive, is the expense connected with soluble pessaries, and the fact that they are constantly being used up, creating the necessity for a fresh supply. A woman cannot always get the new box when she needs

them: she hasn't always got the shilling or the half-crown to spare. I feel convinced that no contraceptive which needs constant renewal offers much hope of success amongst the very poor.

Another criticism which has been offered against soluble pessaries is the use of quinine, which, it has been alleged by some, causes sterility. I know at least one birth-control clinic where this view is held. Their belief in quinine as a powerful contraceptive agent is based on the knowledge that many young couples, living in tropical countries where quinine is taken constantly as a preventative of malaria, have no children although, apparently, using no other preventatives. Whether the small amount of quinine contained in soluble pessaries is absorbed, and whether it has any deleterious effect, is yet to be proved. While we usually suggest lactic-acid pessaries when we recommend soluble pessaries at all, we always keep the quinine pessaries for those who prefer them. And we now recommend to practically every patient who is fitted with the Dutch pessary the use of a small quinine and urea tablet in conjunction with it. Whether the Dutch pessary used with the quinine tablet will prove a more efficient contraceptive than the Dutch pessary used only with a contraceptive ointment remains to be seen.

We have occasionally recommended a sponge medicated or used in conjunction with soluble tablets, but we have never found any patient who liked this method well enough to persist in its use. One patient, who had determined to abandon contraceptives in order to have her fourth child, very kindly undertook to experiment for a time with various methods. The interval was too short to

prove the efficiency of any method, but her experience with the sponge is worth noting. She was instructed to soak the sponge in vinegar. She found it cold and unpleasant to use, and her husband found the vinegar much too stimulating, so that the climax in his case was very much hastened.

In conclusion, a word must be said on behalf of the working man whose alleged excesses and lack of self-restraint have been the subject of so much indignant moralizing on the part of birth-control opponents. The great majority of the men whose wives have visited our Clinic are extremely moderate and self-controlled. There are a few who indulge in nightly *coitus*—one or two so abnormal that an even more frequent demand is sometimes made. But it was a genuine surprise to me to find how many couples indulge only moderately: how many habitually leave intervals of two, four, or six weeks; how many, in reply to my question, answered, "Oh, three or four times a year"; how many others practise abstinence over long periods—six months or a year, after the birth of a child; and how many others have adopted abstinence permanently.

There can be no question that total abstinence is a successful contraceptive. There seems to me considerable question whether it is satisfactory. In the case of the older couples, work-weary and worn out, abstinence is apparently not a severe effort. But some of the younger women have told me what a strain is imposed upon both themselves and their husbands. The wife always felt the necessity of restraining any demonstrations of affection for her husband, and of meeting his affectionate overtures with

coldness and rebuff, until gradually there grew up an icy barrier between them which both felt and recognized, but which they could not alter so long as abstinence was enforced. If only these couples could have known of some certain contraceptive they might have been spared much pain and much lost happiness.

There is, furthermore, overwhelming evidence to prove that nothing short of complete and continuous abstinence will suffice if this method is to be relied upon as a preventative of unwanted pregnancies. We have one patient who had been married six years. The couple had indulged in *coitus* just three times during their married life, and three children resulted! Our patient was unusually charming, attractive, and intelligent, and gratefully accepted contraceptive advice as a way out of a difficulty which was becoming a serious matter. Another patient reported six years of abstinence, following the birth of two children, both affected with tuberculosis. Her husband was a clergyman, and they both took a grave view of their responsibilities in producing any more children who might also prove unhealthy. The wife confessed that the strain had increased year by year until the situation had become almost intolerable. Both felt that life was not worth living if they had to continue under such a strain. Lord Dawson's view of abstention seems emphatically borne out by the experience of our patients. He said: "Such abstention would be either ineffective or, if effective, impracticable and harmful to health and happiness. Sex love has, apart from parenthood, a purpose of its own. It is something to prize and cherish for its own sake. It is an essential part of health and happiness in marriage.

. . . More marriages fail from an inadequate and clumsy sex love than from too much sex love."[1]

There seems to me, among the cases I investigated, abundant evidence to lay at rest those alarming predictions of unbridled lust if ever couples are provided with a certain and simple contraceptive. Men whose natures and training impel them to exercise unrestrained rights over their wives in the matter of sex do so now, irrespective of undesired pregnancies. There is no reason to suppose that men who now maintain a courteous and thoughtful respect for their wives would suddenly become unrestrained brutes if their fear of causing an unwanted pregnancy were completely lifted.

It is easy to find out what happens in the lives of workers. We assume our right to inquire into their most intimate emotions. It is not so easy to learn what is going on in other circles. But if one may hazard a guess it might be this: that the workers would compare very favourably with those in more fortunate circles on the question of moral restraint.

This would certainly be the case, I think, if the disabilities under which many of the workers live were taken into account. In their tiny, overcrowded houses there is never an opportunity for a separate room for husband and wife, or even a separate bed. And usually they have none of the intellectual diversions available to those in more fortunate circumstances, such as books, and the inclination to read them; music and plays, and the price of a theatre or concert ticket, and all those pleasant

[1] *Medical Views on Birth Control.* Published by the Workers' Birth Control Group.

hobbies which are so diverting to those who are able to indulge in them. The worker's toil-filled days do not leave much time for relaxation and pleasures, and his scanty education does not equip him with the ability to seek and enjoy intellectual pastimes. Indulgence in his sex appetite is all that is left him. One working man said that the only pleasures he got out of life were his glass of beer and intercourse with his wife. Judged from this man's point of view, abstention, to say the least, is impracticable.

Mention has already been made of cases in which deliberate abortions were effected through the use of drugs. I do not know of a single case amongst our own patients in which abortion was brought about by mechanical means, but many of the women I talked with told me fearful tales of abortions produced amongst their friends by the use of a knitting-needle or a similar implement. Many of our patients attributed their miscarriages to causes which sometimes seemed fictitious, and I often felt convinced that a fall from a chair or a sudden fright (the reasons they gave) had occurred at a moment when a timely explanation for a miscarriage was needed. More than one of our patients confessed that they had tried to bring on a miscarriage by jumping repeatedly from the kitchen-table to the floor, or by running frantically up and down the stairs, or by walking until they were too tired to go any farther, or by standing on their feet all day and never sitting down until they could not stand any longer. Gin and quinine, or some similar combination, has been frequently taken in large doses, and patent pills are quite often employed—but without often succeeding

in their object. One of our patients had five miscarriages out of nine pregnancies, but she has always insisted she did not know the cause. I feel quite certain that she has produced them all herself. Many of our patients have at one time or another applied to their chemist, who has supplied them with "medicine" which usually "didn't do no good".

Ninety miscarriages out of a total of 1,081 pregnancies are recorded amongst the 247 patients whose record we have been discussing. It is very difficult to determine exactly how many of this number have been self-induced abortions. Women who will talk quite freely on other aspects of the subject seem singularly diffident where abortions are concerned, which leads to the inference that many more have been self-induced than are confessed. Dr. Campbell's *Report on Maternal Mortality* suggests that there is probably some relation between the practice of self-induced abortion—especially in industrial areas—and the high and increasing rate of maternal mortality; and there seems to be a certain amount of evidence that artificial abortion is spreading more and more widely, even in country districts. A satisfactory contraceptive, with adequate means of making it available to women, would go a long way toward eliminating this source of ill health and mortality.

It is extremely difficult to produce much scientific evidence as to the physical effect of contraceptives. As I have already mentioned, women have a very great antipathy to being physically examined, and we can seldom induce a patient to submit to an examination unless she considers it absolutely necessary. Some of the patients

who visit the Centre and decide to use the sheath as their preventative against conception, for instance, will not consent to be examined at all. Many of the successful pessary cases come back from time to time for new supplies, but we can seldom induce them to be examined again. They say that they are getting along splendidly, and the pessary is just as satisfactory as ever, and they don't see any point in consulting the doctor again. A few patients can be induced to have a re-examination from time to time, and any evidence as to the physical effects of contraceptives must be gathered from these few, and from statements made by patients as to their general health after using the pessary or other contraceptive for some time.

Our doctor has never found any evidence whatever, amongst those whom she has re-examined, of any harmful results following the use of a contraceptive. I have already mentioned those cases who gave up the pessary after a trial because it caused "bearing-down" pains, or in one case haemorrhoids. I am speaking here of those who have actually persisted with the use of an appliance, and have since come back for re-examination.

Erosions and inflammation of the cervix are frequently present when the patient visits the Clinic, but this condition is not increased by the use of contraceptives, and is often relieved by douching. Many times a condition necessitating medical treatment is discovered when the patient comes for contraceptive advice, and these women are always referred to the hospital for treatment. The doctor has always watched especially for early signs of cancer, both before and after the patient used contraceptives. One

or two cases in which cancer was suspected on their first visit were sent to hospital. This may, in fact, have given rise to the story that circulated in Cambridge that *all* our patients were sent to hospital next day. But there has never been the slightest cause to suspect that contraceptives promote cancer.

The general health of many patients has notably improved after successful use of contraceptives. They say that they feel better, and particularly that their nervous condition is improved when the worry and anxiety about unwanted pregnancies is lifted.

We have no evidence whatever that any contraceptive causes sterility, though it may be contended with justification that the period covered by our investigation is too short to show results on this question. The overwhelming difficulty seems to be, however, not that contraceptives cause sterility, but that they fail to prevent conception. The great majority of our patients, as we have already seen, had attempted to limit their families by some means or another over a considerable time before they came to our Clinic; the period during which some contraceptive was used is not restricted to the time covered by our investigation. All our patients (five in number) who gave up their contraceptive to have another child achieved their purpose without difficulty; one had two deliberate pregnancies. And, as we have seen also, a number who used the pessary with the contraceptive ointment for a considerable period became pregnant eventually in spite of it. It happens not infrequently that a failure follows successful use of a method for two or three years. If contraceptives caused sterility it might be supposed that the

continued use of a contraceptive over two or three years would begin to exert the sterilizing influence.

The following case illustrates this point. A patient registered at the Clinic in the autumn of 1926. After using the pessary for four or five months with success she wrote to us: "I would now like to tell you what a difference to both my husband and myself the pessary has made. The constant dread of bringing another little mouth to feed into the world, that we could ill afford, has gone, and in consequence something new has crept into our home, and we are both happier in our married life. I may have expressed myself badly, but I think you understand." She sent for new supplies from time to time, so that it was evident that she was following out her instructions. Almost two years later—at the end of 1928—came this pathetic letter: "I don't know quite how to write to you, because I feel that I have let you down. I have been so confident that nothing would happen to me, but I have to write and tell you that I am almost certain I am to have another little one. Will you help me? My husband is living a hundred miles away from me and is only able to get home every four weeks. I have no friends in N—— and live alone with my two little boys. Is it asking too much for your doctor to give me a thorough examination and so tell me if there is anything really seriously wrong which caused me such a terrible time with my last little boy? The doctor who was with me then has retired and therefore I am at a loss to know quite what to do. Could I get into —— Hospital for the occasion, and if so, would you help me? I feel I am asking a lot, but I hardly know what to do."

And again, after the pregnancy had been confirmed, she wrote: "It was really a big disappointment to me as I had always had such faith and been (as I thought) so careful in adjusting the pessary. We had so hoped that I would have kept all right until after my husband had a better position, as I have found it a struggle with my two little boys, and especially as I live alone, my husband being stationed at A——. Unfortunately I have been so horribly depressed, although I have tried hard to fight against it, but the winter has been so long and dreary without my husband's companionship."

This too prolific case and others like it are the source of anxiety and worry at the Clinic—not the theoretical case sterile from using contraceptives, which in actual practice we have never met. Until it is possible to gather evidence from a considerable number of cases, under conditions which make it possible to separate completely the case which is naturally sterile, whether or not contraceptives are employed, from the naturally fertile case which becomes sterile after using contraceptives, we are justified in refusing to accept the unsubstantiated statement frequently made by some practitioners that birth control produces sterility.

Sterility and injury caused by contraceptives—this is purely theoretical speculation which opponents of birth control may indulge in if they like, and which believers in birth control may reject with equal justification. But the agony and suffering caused by the lack of contraceptives —this is not theoretical speculation. This is fact which can be supported by the testimony of thousands of women, dragged down and worn out before they have

reached middle age; by thousands of unwanted children born to privation and poverty; by thousands of doctors and social workers who are witnesses of this needless and colossal waste.

It is to deal with this known and pressing problem that we plead for birth control; it is to bring conception within conscious and certain control, so that cases like that just quoted—so happy and confident in her first letter, so disappointed and depressed in her last—need not arise, that we plead for scientific investigation into more satisfactory methods.

CHAPTER X

UNROMANTIC REALITIES

MUCH nonsense about "mother love" has been written and believed. No one would deny the power and depth and richness of the emotions felt by a mother toward her child. This is amply demonstrated by the years of drudgery and self-sacrifice which thousands of women spend in the service of their children. But there is a limit to even so powerful a force, and when mother love is stretched over and over again to embrace children whom the mother did not want, whose coming she deeply resents, whose arrival is accomplished by an agonizing and dangerous process which she had no desire to undertake, whose advent means less food and care for the children already born and more work and worry for an already overburdened woman—when mother love is subjected to such a strain, it is not surprising if it becomes exceedingly thin. Those who have worked amongst the poor, and who have the hard common sense to face realities unclouded by sentimental fancies, know full well that hundreds of children are born and grow up without ever knowing a mother's love. Surely it is not desirable for children to be born who are received only as a miserable new burden, who occasion no joy in their parents' hearts unless happily they succumb to the adversities of their surroundings and die. "Churchyard luck"—that is how hundreds of poor women regard the death of a new infant; that is how their neighbours refer to the rapid exit of the unfortunate child.

One of our more intelligent patients lost her ninth child—I have already quoted her letter about the birth of this infant. When I went to see her afterward she said to me, "I was glad when it died, it's no use me saying I wasn't. I never wanted it, and I couldn't have done for it what I wanted to if it had lived. I got more now than I can feed properly. Three of the other kiddies who need boots have got to go without until I get the funeral paid for. The nurse, and getting that little thing buried, cost me £5. And I ain't fit yet to get back to work." We have happily been able to avoid a recurrence of such tragic waste in this case, for the patient has used the pessary with success ever since her baby was born.

One day one of our old patients came back for new supplies. We sat chatting for a little while, and she said to me, "Have you heard that Mrs. A. has got her new baby?"

"No," I said. "Isn't that fine?" trying to make the best of the business, as I knew the pregnancy had been undesired. "Is it a boy or a girl?"

"I don't know", answered our patient. "I never thought to ask. I don't know whether she knew herself. You know you don't care after your fourth or fifth. When my sixth baby was born the doctor comes in and he says to me, 'You've got a nice little boy. Did you want a little boy?' And I says to him, 'No. I'd rather have a chest of drawers.' "

Women are becoming more honest and more informed. They are beginning to see through some of this traditional trickery about these Little Gifts from Heaven, and this Divine Mother Love which has so long been assumed to

act as an effective anaesthetic for all accompanying woes. They frankly admit that after their family reaches a certain stage they don't want the succeeding children who are born to them. Many elderly women have said to me: "If I had known in my young days what the young folks know to-day you can believe I wouldn't have had the big family I did."

This letter, from one of our patients, is quite typical of the sentiment very frequently expressed:

Just a line to let you know I received the pessary safely. I am putting you in a shilling order for now I will send the other shilling a little later on you ask me in your letter if ever me or my husband ever tried any method of birth control, no we never have until Mrs. K. told me. I wrote for some book on birth control that was not until I had my last child if I had know before I don't think I would have five children to look after as a mother wants a lot to do on to keep them as you ought to, I have four boys and one girl the boys are all strong and healthy the little girl not very strong, she has been a lot of trouble she did not walk till she was 3½ my oldest boy will be nine years old in January, the youngest is two years now, it is a treat to have my arms free. I will try and come to the Clinic I hope some time in the new year, you must excuse letter I am sorry to say I am not a good letter writer.

I well remember the pain and pity I felt for two little tots about four and five years of age who stood solemnly watching me one day as I talked to their mother. Pointing to them she said, "I didn't want either of these". Can we calculate the pain felt by children who know that they were not wanted, that their parents regard them as a burden? I was reminded, as I looked at them, of that tragic elder son of Jude the Obscure who, having accom-

plished the end of the younger children and himself, left a mournful note to explain the tragedy: "Done because we are too menny."

It isn't that women are afraid of the pain and danger of childbirth. It isn't that they want to "shirk their duty" —they don't consider having children a duty at all. They *want* children. We have had only two or three patients amongst all who have come to the Clinic who wanted completely to avoid children. And their reasons were sensible enough. One had to look after her husband's aged father, who was a helpless invalid requiring more care than a baby. Another had married rather late in life a man who had lost his first wife in childbirth, and he was much too frightened to allow his second wife to face the same danger. Another couple had decided on a childless marriage for well-founded eugenic reasons.

They want children, but they want to choose the time and the number. They are taking a responsible view of the future. They are ambitious for their children, and they are prudently looking ahead to the increasing demands which will be made upon their resources as the children grow up. If there is one phrase which I have heard more often than another amongst our patients it is this: "You can't do for them what you'd like to when there're too many." That is the foremost reason for wanting to curtail the size of families. That is the pivot of the whole situation. The following letter may be quoted as typical of others received from our patients:

I am 43 and have four children the youngest is 21 months. We have a great deal of worry and anxiety and I am always overworked and feel quite unfit mentally and physically to

have another child, it upset me too at the time very seriously mentally, one Doctor said I ought not to have another child. Our expenses too are very heavy and we cannot do justice to the other children if another arrives.

The producing of children is becoming a function of conscious intention, knowledge, forethought, and prudence—qualities which are highly praised when exhibited by the workers in any other sphere of life, but which are condemned as evidence of selfish and wilful disregard of "duty" in favour of carefree pleasures when applied to this important question of bearing and rearing children. The women I have talked to deeply resent this insinuation that their wish to apply contraceptives is prompted by "the desire to secure comfort and to avoid trouble, and perhaps on the part of the woman an exaggerated fear of the pain and other disabilities *assumed to be associated with childbearing*".[1]

The italics are mine, but they only feebly express the indignation I feel with such a statement when I review the case histories of this small group of women I have dealt with, and realize that the pain and agony they have suffered, not only in childbirth, but in years of impaired health, resulting from overwork and from too many and too frequent pregnancies, must be multiplied a thousandfold to embrace the fate of women all over the land. I appreciate the comment of a mother of eight, who said with a good deal of bitterness: "I wish *he* could have had the second—there wouldn't have been a third."

[1] *Medical Aspects of Contraception*, p. 14. This is a report issued by the Medical Committee of the National Council of Public Morals. The statement quoted is signed by ten gentlemen and two ladies.

It would be sufficient, perhaps, if husbands could occasionally be at hand during the hours of labour, in order to have some conception of the physical pain which their wives are enduring. I recall the case of one patient who had tried the pessary without success. She had often suggested to her husband the desirability of using a sheath, but he felt disinclined to take the trouble, and eventually a sixth pregnancy occurred. On all five previous occasions the husband had been away from home when the child was born. On the sixth he was present, and his amazement and consternation when he learned how difficult the business of bearing children is, and his compassion when he realized that his wife had already endured this great physical strain five times, led him at once to resolve that there would not be a seventh. He has taken the greatest care to use the sheath ever since.

Dr. Giles, speaking before the same Medical Committee of the Council of Public Morals, while agreeing that "there are well-defined conditions when it is all-important that birth control should be done", fears "that that teaching may be abused, as all people would start their married lives with the intention of limiting children right away. . . . Many couples do it, as their idea is to have a good time before they have the responsibility of parenthood."[1]

It is difficult to think of any good reason why young couples should *not* have a good time before they have the responsibility of parenthood. The first few months of adjustment to this new and strange state is often

[1] *Medical Aspects of Contraception*, p. 137.

difficult enough without the complications of pregnancy. One of our patients told me what her experience had been. Both she and her husband had been brought up by parents who held the rigid view that ignorance is innocence, and neither of the young people had been prepared for the responsibilities they were jointly taking up.

Marriage isn't always as rosy from the inside as it looks from the outside [she told me]. You see, I became pregnant on my wedding-night, and right from the beginning I was terribly sick. We started out with a lovely little house, but I was too seedy to finish the odd jobs of settling we had left to do after we got married. I could hardly get my husband's meals. We had both worked and saved, and planned little trips we could take together, and fun we could have, but we never dreamed we'd have a baby straight away. Then the next year the second baby came. We never have an evening out together; one of us always has to stay home with the kiddies. And if we could get out together there's hardly enough money left to buy a cinema ticket. Of course I love my husband, and we wouldn't give each other up. But both of us feel that it would have been a good bit easier if we could have waited a little before the babies came. We always meant to have babies, but we don't like the feeling that we were hustled into it.

I doubt whether this young woman, or, for that matter, a great number of our patients, would appreciate (or understand) the following view held by two members of the same committee:[1]

"The persistent use of contraceptives by the newly married and by other married people in cases where no medical reasons call for their use may, by promoting a

[1] *Medical Aspects of Contraception*, p. 20. Memorandum of Sir Arthur Newsholme, K.C.B., and Professor Leonard Hill, F.R.S.

lowered outlook on life and too physical a conception of the marriage relationship, and by causing the loss of those elevating effects on character produced by parenthood, be detrimental to the basis of character on which—as we now increasingly appreciate—a healthy personality is built."

Or this from the Bishop of Guildford:[1] "It is impossible to adopt such practices without a coarsening of sensibility. I believe that any pure-minded girl, uncorrupted by sophistry, shrinks from these methods with an instinctive repugnance." I can speak here only of the young married women among the workers with whom I have talked on this matter. I *suspect* that they are as "pure-minded" as young girls to be found in many other circles; and I *know* that the fear of unwanted pregnancy is the thing which fills them with repugnance more than anything else.

Commissions, committees, clergymen, doctors, economists, moralists—between all these and many others the population question continues to be warmly debated from almost every view-point. They debate whether we shall reach a stationary population, and when, and whether this is desirable, or whether women ought not still to go on bearing excess children in order to fill the empty places of Australia before some foreigner gets there. They debate whether women should not produce more workers for the factories and more sons for the army; whether population is outstripping the means of subsistence or whether "race suicide" is not the most pressing danger; whether more men of genius than

[1] *Ethics of Birth Control*, p. 150.

feeble-minded are produced by uncontrolled breeding; whether the children in large families are happier or better cared for than those in small; whether birth control is always a sin or sometimes admissible, and whether it has ethical justification; whether it can be allowed within limitations prescribed by the debaters, or whether it shall be forbidden completely. All these experts, writing, sitting on committees, appearing before commissions, are doing useful and illuminating work. But I have a suspicion that a great deal of this discussion is purely academic; for it passes over and ignores the one essential and vital factor in the population question—the woman who has to bear and rear the children. For even if and when the experts in these discussions come to some definite decision, the enforcement of their view will not be too simple. It will not, for instance, be at all easy to compel women to bear sons to swell the ranks of the army; and I think it quite safe to label as purely academic the anxiety on this score exhibited in the Second Report of the National Birth Rate Commission:[1] "But in the event of a war similar to that which we have just experienced, what would happen to us with a greatly reduced birth-rate? Surely all we have would be taken, and we must become slaves—as we should be to-day if we had entered on the struggle with Germany without adequate man-power. Moreover, what would happen to our Empire?"

Instead of summoning bishops and priests to testify what they think women think about contraceptives, and about the merits of uncontrolled breeding, would we not

[1] *Problems of Population and Parenthood*, p. 73.

reach sound facts sooner if women themselves were summoned to say what they think, and what their experiences have been with and without contraceptives, and indeed, what they intend to do about family limitation? For however distasteful it may be to Dr. Sutherland,[1] the question must ultimately more and more rest for final decision with the woman, simply because schemes for compelling reluctant women to undertake undesired pregnancies will be so little feasible. The only effective agent of compulsion will be ignorance, and ignorance, once the light of freedom and education has penetrated, is difficult to enforce. So long as there are contraceptives —even though they are difficult and not always effective— women will make the attempt to limit their families.

The Medical Committee of the National Council of Public Morals, for instance, would have done well to summon the mother of eighteen children around whom so much discussion took place. Dr. C. Killick Millard, in his evidence before the Commission, mentioned his gardener's wife who had borne eighteen children.

Dr. FAIRFIELD (one of the Commissioners): Take the case of the fertile families; can you measure fertility and say that Nature has made a mistake? Even where you have eighteen children, is it not possible that Nature knew more about that stock than we did?

Dr. MILLARD: Of course you can suggest that, but I am

[1] "She is to be under no obligation in this matter either to her husband who supports her, to the State which safeguards her, or to God Who created her. Moreover, by suitable instruction, she is to be given the privilege of practising contraception without the knowledge or consent of her husband. That is a claim for Feminism which no sane man would admit, or which, if admitted, would destroy the very foundations of our civilization."

suggesting as intelligent human beings we have to decide independently of Nature, and most people would say that eighteen children would be more than they felt equal to.

Dr. FAIRFIELD: Is it an economic problem?

Dr. MILLARD: Not entirely. Most people would say that it is too big a strain to have eighteen children in twenty-five years.

Dr. FAIRFIELD: But was it?[1]

For the correct answer, ask the mother of the eighteen.

Ask any mother of half that number. Ask this wife of a schoolmaster who came to us when she was pregnant for the ninth time. After her visit she wrote: "Of course I am sorry that I am pregnant as I have already 4 children under two years of age, but the other twin has begun to go a few steps this week, and baby is now 6 months old, so I suppose I shall get through. The 6 bigger ones are getting useful."

Many others among our patients could throw some light on the question whether or not the strain imposed by prodigal Nature with these large families is greater than women ought to be asked to bear. Let me quote the letter of a woman living in a tiny cottage in a village near Cambridge: "I hope you will excuse me for writing to you, but I feel that perhaps you can give me some advice as I have 8 children the eldest 10 years, and 3 under two years twin babies, and I am not strong and I feel it will be too much for me to have another one. We do not know how to make ends meet now and with another one I cannot bear to think of it."

And another patient from a small town near Cambridge: "I am the poor Mother of 6 children in 8 years, and my

[1] *Medical Aspects of Birth Control*, p. 117.

baby is 2½ years old, I have been attending the —— Clinic for 6 months now, but Tubercular, I have very bad legs any time so I dread the future."

Both these women were pregnant and have since produced another child. This looks very much like an "avalanche of babies".[1] These cases are not typical of every case, yet they occur frequently enough, and are tragic enough not to be dismissed simply because they do not represent the "average". Even when pregnancies are much less frequent the addition of one single baby is often enough in the nature of an avalanche sufficient to beat down parents who are already on the border-line of poverty and despair.

It is so obvious that many of those who are preaching the merits of large families have no conception of the day-by-day life of the women whom they are exhorting. This argument, for instance, appearing in the *Ethics of Birth Control*,[2] can scarcely apply to working women who constitute such a large part of the population. "Nor is it wise to forget that the very fact of being a member of a fairly large family, say, of anything over four children, itself enhances a child's preparation for life as much as the fact of being an only child, or one of two children, hinders it. Playmates in the nursery are more important than the parents' ease." I have often quoted this passage when addressing an audience of working women. The

[1] "In the ordinary married life of the young, usually an interval of about two years elapses between births; and after the age of thirty this interval usually increases. This has been the experience of large communities before modern 'birth control' was known. Hence to speak of an 'avalanche of babies' as almost inevitable unless preventive measures are taken is inaccurate and misleading" (*Medical Aspects of Birth Control*, p. 4).

[2] Page 11.

notion that they have nurses and nurseries for their children has never failed to raise derisive laughter.

The nursery of the children of the poor—it is the street, the gutter, the doorstep, the tiny court where their miserable dwellings are crowded, door to door. Here the children of the poor find playmates in plenty. The multiple companionship of the nursery is much more important for the wealthier classes, though even here the disadvantage of the small family has been greatly ameliorated by the modern development of nursery schools, and the traditional habit in England of sending children away to school at an early age. For the father whose economic circumstances permit, and for the mother who feels herself competent to undertake the responsibility, nothing could be more interesting or more ideal than a large family. I know numbers of intelligent women who look with envy on the large families of their more fortunate friends, when they themselves must be content with two or three children. Large families by all means when it is a matter of choice and not of chance.

But among the workers it is particularly noticeable that a father or mother who were members of very large families are the ones most eager to avoid a large family themselves. Women who have brought up a "quiverful" themselves bring their daughters and their daughters-in-law to the Clinic. "I don't want my children to go through what I did", is an exceedingly common remark.

Another thing which I have noticed again and again is the active interest mothers of small families take in the work and progress of their children, as compared

with overburdened mothers whose energies and interests are entirely consumed in washing and cooking and "doing for them". When there are two or three children the money will often stretch to music lessons, and to materials for developing hobbies and hand-work, and the progress made by the children is a source of endless pride to parents. These children get some of the niceties as well as the necessities of life. It seems a laudable ambition for parents to wish their children to have better opportunities than they themselves had. Fewer children, but more education—that appears a more sensible way of dealing with the problem than the suggestion put forward by the authors just quoted where more children and, if necessary, curtailed education is the ideal held out.

"At a time when the greater part of the population leaves school at the age of fourteen it seems hardly reasonable for people in another social class to assume that an education in public school and university is essential, and that unless such an education, or its equivalent, can be assured the births must be reduced."[1]

But if the ideal of smaller families, given better opportunities, is to be realized, the pressing need for a simpler and more effective contraceptive than is now known becomes apparent. We must have something that will effectively solve the problem in the case of those more intelligent women who seek help, and that can be urged upon those feckless individuals who through a feeble mentality go on assuming responsibilities which they cannot carry, and which must eventually become the burden of the State. And the research into effective con-

[1] *Ethics of Birth Control*, pp. 10–11.

traceptives must be accompanied by a campaign to establish a more sane and sensible and healthy attitude toward the whole question of sex relationships, before anything permanent in race betterment can be accomplished. Taboos must be lifted, and the sex relation must be freed from the widely accepted assumption that it is sinful and shameful; it must be brought into the light of understanding and control. And simple physiology must be taught to the young, so that when they enter marriage they will not be burdened with a load of ignorance, fear, superstition, and prudery which so often makes a happy adjustment between husband and wife all but impossible.

Until then we shall often fail to apply contraceptives in exactly those strata where limitation is most necessary, because the women much more easily believe the weird tales they hear about the evils of birth control than they can comprehend simple physiological facts.

I remember one woman who refused to use a contraceptive because she had heard that every woman who came to our Birth Control Clinic was promptly taken to the hospital the following day for an operation. She wasn't going to be carted off to the hospital herself and have her insides cut out—not she! She lived in a house which had one room opening on the street and one room in the basement completely under the street level, and dependent on artificial light. Her seven small children swarmed round me as I stood at the door, and their mother, in intervals of telling me what a devoted mother she was, and how righteous it was to accept these little gifts from Heaven without interfering with Nature,

made frantic swoops at the wriggling members of her brood, occasionally getting home a smart smack. She was much more convinced by the "black magic" gossip of her sordid street than by the sober truth about birth control. Her family was an almost continuous charge on the Board of Guardians.

From other women I learned that the use of any contraceptive caused cancer, tumour, tuberculosis, insanity, "fits", and every known kind of "social disease". Besides, hundreds of women lost their appliances inside their bodies, and had to go to hospital. One of our patients—by no means of the dirty and slovenly type—told me that she and her husband had given up the sheath, which they had used with success, because a cousin of theirs "lost hers inside. Then she tried to get it out with a safety-pin and died in the hospital." This was, of course, a self-attempted abortion which had proved fatal, and the couple resumed the use of the sheath after I had given the wife an elementary lesson in physiology.

Sometimes, even after instruction at the Clinic, a patient will write in great anxiety to know whether it is possible for the pessary to get lost inside, or whether this or that story she has been told about the ill-effects of contraceptives is true. One letter will suffice as an illustration:

Dear Friend just a few lines to say i am quite well hoping you are well . . . does it injure a Mans health to use those sheaths as my husband has gone so thin and i thought that was the Cause i felt sure Dear Friend that you would help me.

Many of the stories which find circulation amongst the

poorer districts can usually be traced to some incident connected with an attempted abortion either by mechanical means (such as the safety-pin incident) or through drugs which have caused a serious illness. Abortion and birth control are regarded by the misinformed as the same thing, and it is often difficult to induce the prejudiced to make the essential distinction—whether the prejudiced be found amongst the rich or the poor.

The old wives' tales believed and practised amongst many women in the hope of avoiding conception are as curious as their ideas of modern birth-control methods. Many believe that if they avoid an orgasm, conception cannot take place. One of our patients—I should class her for intelligence as rather above the average—told me that she thought of everything she could so as to distract her mind during *coitus* in order not to reach an orgasm—she thought of what she was going to prepare for dinner next day, and of what she was going to buy at the shops, and how she was going to remodel some garment for the children. This woman's husband is now using the sheath with success. Others thought that they would "keep out of trouble" if they sat up immediately and coughed violently; still others relied on rising at once and urinating, faith in this method being based on the belief that the vaginal passage would thus be washed out!

Clearly there is a long road to travel before a sane and enlightened attitude toward the whole question of sex can dispel these forces of ignorance, prejudice, and superstition. Meanwhile, as Sir James Barr has so aptly pointed out, "Large numbers of infants appear in the

world with no other ostensible object than to provide work for doctors and undertakers. Anyone dying under twenty years of age is an economic failure who has cost the State a large sum of money which he has had no opportunity of repaying."

CHAPTER XI

AN APPEAL FOR RESEARCH

IT has sometimes been suggested to us that the day is past when birth control clinics are needed; that everyone already "knows what to do". This was, in fact, the reply given by the first doctor I approached in Cambridge about starting a clinic. But it is abundantly clear that everybody does not know what to do; further, that even when methods are known they cannot always be applied with success. All over the country husbands and wives are facing this problem of unlimited families with anxiety and forebodings. It is not a problem affecting a few isolated cases. It is practically universal amongst married people. The couples who have solved the problem to their satisfaction are in the vast minority. The great majority of husbands and wives in all walks of life are deeply perturbed over this question. It is causing endless misery, unhappiness, and ill-health.

Yet we seem very far from a solution. There is no thoroughly satisfactory method which will meet the need of even a majority of the cases. There has been almost no scientific research into this important subject. No substantial contribution to the technique of birth control has been made in fifty years. Medical schools are turning out thousands of students each year without adequate knowledge of contraceptive methods; birth control is not included in the curriculum of any medical school. Doctors who believe that the work of medical men is seriously handicapped through ignorance of methods of

contraception can acquire that knowledge only from clinics, or through methods of trial and error in which quite often error predominates, as many couples have learned to their sorrow. Family limitation is not easily achieved, and every doctor does not know instinctively what to advise. Contraception technique deserves study and skilful mastery. The medical profession has too long regarded contraception as "a minor factor in life"; it is, on the contrary, a veritable corner-stone without which it is frequently impossible to promote the health and well-being of a family.

Yet this highly important question is shirked. The field has been left untouched, and individual doctors here and there who would like to aid their work of health-building by offering contraceptive advice have to work in the dark. Medical men who do not want to give the advice say that they cannot, because "so little is known about birth control". Too true! But when will some effort be made to dispel this ignorance? The need of wider knowledge on this subject is recognized by many members of the profession. "I have no doubt whatever", says Dr. Killick Millard, "that birth control has come to stay, and it is up to the medical profession to act in the matter rather than leave it alone and allow it to drift. At present the profession is working largely in the dark, but we should be in a position to tell the people what to use and what not to use."[1]

Surely people should be able to turn with assurance to their medical advisers in this matter. Instead of which they have to seek their information often in the most

[1] *Medical Aspects of Contraception*, pp. 122, 123.

roundabout way, and frequently from the most unreliable sources. Take this instance. A man living in Ireland read an account of a debate on birth control which took place in the Cambridge University Union Society. He had made an earnest effort to limit his family by such means as he knew, but without success. He snatched at the straw of the newspaper report, and wrote to the Union Society asking to be directed to someone who could help him. His letter eventually came into my hands. In reply to the letter I wrote to him, the following answer was received. It is such an interesting human document, and it illustrates so well the struggle which is going on in thousands of families, that I quote it in full.

Your letter to hand, for which I sincerely thank you, and I feel very pleased how I got in communication with the Hon. Secretary of the Women's Welfare Association. I need only look at the name of the President and at the personnel of the Executive Committee of your Association to know that your advice and directions cannot be surpassed for the welfare of men as well as women.

I am married over thirteen years and have ten children—six boys and four girls—you will find their names and ages on the appended sheet of paper. I have only £2 per week earnings which you know is not much for the support and general upkeep of a husband, wife, and ten children. However, we are happy if we can stop at that—and we expect to pull through all right in the management of the ten with God's help.

On November 1st, 1920, my wife had a baby son two months before the natural time, the same boy is weak still, from thence on I tried not to have any more children as I then had six in family. I had only one method to adopt, namely, to withdraw from my wife at the critical moment the seed was to enter the uterus. I found that distressing, and nature was always able to get the better of me, with the result

whilst trying that practice I increased my family by four children, and my wife also had a miscarriage last July, and had to undergo an operation last September to scrape the womb as a result of the miscarriage.

My views on the subject of Birth Control is that it is a great blessing to husband and wife, and in particular the wife who is always the real sufferer. It is a terrible thing to have a large family without proper means to support them, and also wasting the strength of a nice wife and washing away her beauty.

It is my utmost wish to let you know that the Catholic Clergy are entirely opposed to Birth Control, but I need not state here they are not the sufferers, and even I do not see where religion comes in. If there is any sin it is on those who have large families and unable to support, clothe, and educate them properly. I know privately that the people of this country in general, of all creeds and classes, are for Birth Control, and I am fully certain that a good many husbands carry on the practice of withdrawing at the critical moment.

Again thanking you for your trouble, and I am very grateful to you for your good directions.

His children were born in 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1924, 1925, and 1926.[1]

This remarkable letter adds another link to the chain

[1] While in Ireland, a few weeks ago, I took the opportunity of looking up the writer of this letter. I found his whitewashed crofter's cottage after driving many miles into the hills. I was warmly welcomed by this charming Irishman and his wife, who told me more about their difficulties. They are Roman Catholics, and the use of a sheath—expressly forbidden by the Church—has caused them a great deal of uneasiness. Eventually the husband heard that the "safe period" was a method which could be used with impunity, since the Church allowed this. He therefore gave up the sheath, and, counting carefully twelve days after the wife's period as he had been told, he ventured to have intercourse without mechanical protection. The wife became pregnant at once, and is now expecting her eleventh child. He had no difficulty in using the sheath, and it was only the religious scruple which caused him to abandon this contraceptive. He is now determined, however, that he will use this method in future, since he considers it less sinful to disobey the rules of the Church than to produce children whom he cannot support.

of evidence which is leading many workers in the birth-control movement to feel that in no distant future the Church (like the medical profession) will be obliged to re-examine and revise its attitude toward this important question if it is to retain the loyal adherence of its followers.

Certainly the medical profession must revise its attitude of indifference if it is to escape grave inconsistencies. Numbers of women have come to our Clinic after they had been warned against further pregnancies by their doctors, who gave them, nevertheless, no advice on the prevention of pregnancy. One case I remember particularly, because her doctor had said that another pregnancy within three or four years would probably cost her her life.

"And did he tell you how to avoid this fatal pregnancy?" I asked.

She shook her head.

"Did you ask him?" I persisted.

"Yes," she answered, "and he told me that it was the business of my husband."

"And if your husband would not protect you, what then?" I asked.

"I expect I would have to die," she answered.

It is not stretching prophecy too far, perhaps, to suggest that in some future time a doctor who has reason to believe that a pregnancy would prove fatal to a woman and withholds knowledge for its prevention will be held guilty of criminal negligence.

Yet to-day many doctors, through lack of training and instruction, are unequipped to give their patients advice. Every birth-control clinic receives letters and visits from

doctors who are trying to supply for themselves the instruction in contraceptives which they never received during their medical course.

It is difficult to estimate the disablement and loss of life that might be avoided if the science of medicine included, as a matter of course, a thorough knowledge of some contraceptive methods and a belief in their application. For hundreds of children die in infancy—literally crowded out by the pressure of the children already born. And hundreds of women are prematurely aged and enfeebled by the strain of bearing and rearing too many children.

There are, besides, the women for whom a pregnancy constitutes a grave danger, who ought to be adequately protected. Patients have come to our Clinic suffering from kidney disease, epilepsy, heart trouble, tuberculosis, and various abnormal conditions, such as contracted pelvis, who would run a serious risk if pregnancy occurred. Very often these patients are sent to us by doctors and we are asked to give them contraceptive information which will insure them against this risk of death. Yet for some of these cases there is no suitable method, and for all of them there is the ever-present risk of failure.

The difficulties of research in this field are fully realized. But it is not too much to hope and expect that science, which has overcome colossal difficulties in so many fields, will not find the obstacles to research in this subject insurmountable. It is not too much to hope that the physical sciences which have, through exploration, discoveries and inventions, wiped out many diseases, relieved mankind of many sufferings and increased the

expectation of life, will be applied with equal success to the field of contraceptives.

Lord Dawson believes that "There is no doubt that a perfect method of this kind has yet to be discovered. The determination of further and very necessary knowledge as to the best methods of contraception can only be obtained by animal investigation and carefully collated records in special Clinics and private practice."[1]

Clinics are making a start by collecting and collating records and by follow-up work, which it is hoped may be undertaken on a wide scale. But there is already sufficient evidence that no known methods even approach perfection. The facilities of the laboratory, the skill of physiologists, bio-chemists, and medical specialists must be applied to this pressing and important subject. The discovery of a simple and effective contraceptive method will incalculably decrease the misery and increase the happiness of all mankind.

[1] *Medical Aspects of Contraception*, p. 177.

SUMMARY

Cases covered		300
Refused examination on first visit, came out of curiosity, etc.		14
Came wanting child		6
Came pregnant and did not return and were not given advice		5
General condition only, treated		3
Patients who registered but never received advice		28
Patients receiving advice, out of first 300	272	
Lost trace of and no reply to letters ..	25	
Total cases about which results are known	247	

PREGNANCIES

Total of pregnancies, at first visit or after ..		123
Pregnant on first visit or subsequently before advice received		36
Pregnant after seeking advice about having child		3
Pregnant since first visit and after receiving contraceptive advice		84
Gave up contraceptive to have child ..	6	
Total unwanted pregnancies after contraceptive advice was given	78	

Pregnancies occurring when patient claimed to have used pessary as directed	16
Pregnancies occurring when patient claimed to have used sheath as directed	3
Pregnancies occurring because patient gave up part or all of pessary method	42
Pregnancies occurring because patient gave up sheath	17

PATIENTS

Patients who gave up pessary, but have not yet become pregnant	65
Patients who gave up sheath, but have not yet become pregnant	15
Patients who gave up pessary or failed with it now using sheath..	36
Patients who gave up pessary or failed with it now trying or returning to *C.I.*	39
Patients who gave up pessary or failed with it now trying again..	2
Patients who gave up sheath or failed with it now trying again..	8
Patients who gave up sheath or failed with it now using pessary	1
Patients who gave up sheath or failed with it now trying or returning to *C.I.*	10

Total number of patients not using pessary successfully (including single and double pregnancy cases) 120

Total number of patients not using sheath successfully (including pregnancies) 35

Total number of patients not using sheath or pessary successfully, out of 247 cases 155

Patients using Dutch pessary successfully for periods of

Months. 6 to 12	Months. 12 to 18	Months. 18 to 24	Months. 24 to 30	Months. 30 to 36	Months. 36 to 42
19	24	8	10	5	3

Patients using sheath successfully for periods of

Months. 6 to 12	Months. 12 to 18	Months. 18 to 24	Months. 24 to 30	Months. 30 to 36	Months. 36 to 42
15	15	15	11	5	5

(For successful use of other methods, or combination of methods, see Table, p. 79.)

Patients who had previously attempted some form of family limitation (out of 265) 189

Facts of general interest from the history of 247 cases about which results are known:

Total number of pregnancies 1081

Total number of live children born (including twins) 970

Total number of children surviving 883

Total number of miscarriages 90

Total number of still births 25

Total number of deaths under two years of age .. 72

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